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Physician testifies about assisted suicide

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Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • JANUARY 23 1998



Physicians and
advanced practice
nurses square off on
scope of practice

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ISMS outlines APRN position

DETAILS: Paper now available to members, public. BY JANE ZENTMYER

[CHICAGO] In December, ISMS distributed a paper that outlines its position on the licensure of advanced practice registered nurses. The Society supports recognizing APRNs statutorily and defining their scope of practice. ISMS also supports allowing APRNs to request and interpret laboratory tests as defined in a written collaborative agreement between an APRN and a physician.

"The position paper was put together for public distribution because it seems there

have been a lot of rumors and misconceptions about the Medical Society's position on APRNs," said ISMS President Jane Jackman, MD. "This very plainly states the policy of our House of Delegates, which we think reflects the opinions of the majority of the doctors in our state."

The paper explains that nurses and physicians agree in concept on many issues related to APRN licensure, but "the devil is in the details," Dr. Jackman said.

(Continued on page 10)

Tort reform backers vow to move forward

ANALYSIS: Supporters react to decision and anticipate consequences.

BY JANE ZENTMYER

[SPRINGFIELD] Almost three years after its enactment, the 1995 tort reform law became a victim of an Illinois Supreme Court decision that overturned the entire statute on constitutional grounds. The decision, released Dec. 18 in the Vernon Best vs. Taylor Machine Works case, is a setback to ISMS' efforts toward civil justice reform, but the law's supporters resolved to move forward.

"Despite this temporary setback, ISMS will continue to fight actively for civil justice reform and is confident of future success," said ISMS President Jane Jackman, MD. "We will now expand our focus, politically, to the Illinois judicial system, seeking greater openness and accountability in a process that has repeatedly proved it is out of touch with the public it seeks to protect."

The Illinois Civil Justice League, a coalition of tort reform supporters including ISMS, also pledged to return to the drawing board and take a hard look at the state's judicial climate. For now, the court's

decision returns the law to its prereform status. "This ruling is going to create a mad dash by trial lawyers to file lawsuits," said ICJL President Ed Murnane. "It is once again open season on businesses, doctors, hospitals, local taxpayers and not-for-profit organizations."

The court initially signaled its unhappiness with the Legislature's 1995 tort reforms when it refused to accept amicus briefs from tort reform supporters including ISMS, Murnane said. The court opened the legal process to

supporters only after an informational campaign by ISMS, ICJL and other organizations.

Tort reform opponents tried to persuade justices to "play legislator" from the moment the law was passed, said Sen. Kirk Dillard (R-Downers Grove), and they seem to have succeeded. "The proper recourse and legal recourse for those people who were unhappy with the Illinois General Assembly's tort changes was the electoral process, not the courts."

(Continued on page 14)

HCFA extends grace period on documentation guidelines

CHANGE: Delay allows time to educate physicians.

BY LINDA MAE CARLSTONE

[CHICAGO] The U.S. Health Care Financing Administration has honored an AMA request to delay the enforcement of revised evaluation and management guidelines that were to take effect Jan. 1, pushing the grace period to July 1. The guidelines were jointly developed by the AMA and HCFA and were implemented on a voluntary basis in October, but the agency granted a grace period for mandatory compliance through the end of 1997. That grace period has now been lengthened.

The extension will buy time to iron out problems in the guidelines and to educate physicians about the complex changes, said Ted Lewers, MD, a member of the AMA Board of Trustees. "If we are going to ask physicians to do something, they have to know how it works. The time frame has been relatively short to implement this."

The guidelines have been issued to help physicians understand the criteria that Medicare carriers now use to evaluate patient records during audits.

They provide specific instructions about the documentation that must be in patients' charts to substantiate the CPT code assigned on Medicare claim forms.

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Matt Ferguson

ILLINOIS SECRETARY OF STATE GEORGE RYAN talks to the Bi-Regional Impaired Driving Conference where he was honored for public safety by the National Highway Traffic Safety Administration Dec. 15. Ryan successfully pushed for a new law limiting drivers' blood alcohol levels from .10 to .08.

Illinois Blues opts not to renew carrier contract

MEDICARE: The transition to a new carrier will take nine months. BY JANE ZENTMYER

[CHICAGO] After administering Medicare in Illinois for more than 30 years and in Michigan for three years, Illinois Blue Cross and Blue Shield announced it would step down

as the Medicare Part A and Part B carrier in both states to focus on its rapidly growing private sector business. "This was basically a decision [about] where we're going to put our resources for the future," said Robert Kieckhefer, a spokesperson for the Illinois Blues, which operates as the Health Care Service Corp. in the public sector. The Medicare portion of the Blues' business wasn't profitable, he said.

The Blues' contract expired on Dec. 31, and the company said it would continue administering the program until a new carrier is chosen and ready to go. The transition to a new Illinois carrier or carriers should be completed by Oct. 1, said Dorothy Burk Collins, the regional administrator for the U.S. Health Care Financing Administration. Since 1995, HCFA has completed seven such transitions.

Collins said that the size of the carrier would not necessarily make a difference in HCFA's
(Continued on page 13)

ISMS loans ease students' financial burden

Physicians help future physicians get an education. BY JANE ZENTMYER

Medical students accumulate a frightening amount of debt by the time they graduate, and most search for ways to keep that debt as manageable as possible so they won't face huge payments for many years after graduation. One option for keeping debt low is available through ISMS' Medical Student Loan Program, which offers low-interest loans to second-, third- and fourth-year students.

"For any of us who are students now, we're going into an uncertain marketplace, and anything we can do that reduces our debt load also reduces our anxiety about what we'll face when we get out there," said Margaret Thomas, a second-year medical student at the University of Illinois at Chicago and a member of the ISMS Committee on Financial Aid to Medical Students. The ISMS loan carries a 5.5 percent interest rate, or administrative fee, which Thomas said is "lower than any other interest rate you're going to find."

During the 1995-96 school year, students at private medical schools spent an average of \$23,696 on tuition and fees, and those attending public schools spent an average of \$8,715, according to the latest figures available from the Association of American Medical Colleges. Sev-

enty-nine percent of U.S. medical students graduating in 1994 reported some debt, and most faced an average debt of \$63,885, according to the AMA.

"Certainly any loans you can get at a lower interest rate when you're going through school are going to be more beneficial," said Richard Mason, DO, a general surgeon from Plano.

The low interest rate was one reason Dr. Mason applied for an ISMS loan through his alma mater, the Midwestern University's Chicago College of Osteopathic Medicine.

He has since repaid his loan, but "it was money that was well-needed," he said.

To attract students to primary care, ISMS waives the 5.5 percent administrative fee to students who agree to enter the area. "In the past some people have been more reluctant to go into primary care because they felt, 'I wouldn't get a high salary so how am I going to pay back my loans?'" Thomas said. But interest-free loans ease the financial worry for future primary care physicians by reducing their debt load.

The most students could receive for an ISMS loan was previously limited to \$2,500, but in 1996, escalating costs prompted an increase to \$4,000.



Although \$4,000 may not seem like much compared with the amount most students must pay for tuition, "every little bit helps," Thomas said. "If someone gets this loan for three years, that's \$12,000 of debt that's at a lower interest rate or at no interest [for primary care physicians]. Down the road that's a few years of having much lower loan repayments."

To receive a loan, students must be in their second, third or fourth year at an Illinois medical school, receive the endorsement of their school's financial aid officers, be an Illinois resident and become an ISMS member. Recipients must begin repaying the loan on Jan. 1 of their first year of practice after they complete postgraduate training or five years after medical school graduation.

Since the program's inception in the

1983-84 school year, 1,061 loans totaling more than \$2.2 million have been issued. Of the total, 345 have been fully repaid, and 69 are being repaid. No loans are in default. For the 1997-98 academic year, ISMS allocated an additional \$375,000 to the eight Illinois medical schools, according to the committee. Each school receives funding based on a formula that considers student enrollment and the school's use of the funds.

"Physicians historically have had an obligation to educate and teach those who come after them, and providing these funds offers another vehicle to assist students in their learning process," said Richard Schmidt, MD, chairman of the Committee on Financial Aid to Medical Students. "I'm proud to be a member of an organization that is able to do this for medical students as effectively as it does."

For more information about the loan program or to make a contribution, physicians may call ISMS at (312) 782-1654 or (800) 782-ISMS.

Election delayed in physician collective bargaining

FIRST UP: NLRB will investigate complaint. BY LINDA MAE CARLSTONE

[ROCKFORD] The Rockford Physicians' Council's election to become a collective bargaining agent for physicians employed by the Rockford Memorial Health Services Corp. has been put on hold pending the outcome of an unfair labor practice complaint.

Last month, the council, a democratic, self-governed organization of physicians, filed a petition with the National Labor Relations Board requesting an election to certify the recently formed council as a negotiator with the RMHSC. However, the NLRB blocked the election while it investigates the complaint filed Oct. 9 by the council, said Joy Kessler, assistant to the director of NLRB Region 33 in Peoria.

Council Vice President Frank Nicolosi, MD, said he is confident that the physicians' group has "the votes in place" to produce a favorable outcome when the election is held. The Rockford Physicians' Council gained momentum from the growing number of physician organizations across the country, Dr. Nicolosi said. "It's just a matter of time," he added.

To legally bind the RMHSC to negotiate with the council, a majority of voters must support collective bargaining.

Council officers estimate that 180 of the physicians employed by the corporation will be eligible to vote in the election. Approval by at least 30 percent of the physicians was needed to support the election petition before it could be filed.

An NLRB decision on the complaint should be made by Jan. 23, Kessler said. Once the complaint is resolved, the NLRB will conduct a hearing on an election agreement. The timing of the election will hinge on how smoothly the two parties can work out such details as voter eligibility, she said.

Rockford Physicians' Council officers said the group was established because of member concerns about practicing physicians' lack of involvement in key decisions affecting patient care. On Nov. 19, the council elected Douglas Kaplan, MD, as president; Dr. Nicolosi as vice president; Bruce Jasper, MD, as treasurer; and James Foskett, MD, as secretary.

The group has held weekly meetings since July, recently establishing bylaws and preparing two platform papers on physicians' timely access to patients' medical records and charts, and physician involvement in administrative decisions affecting patient care.

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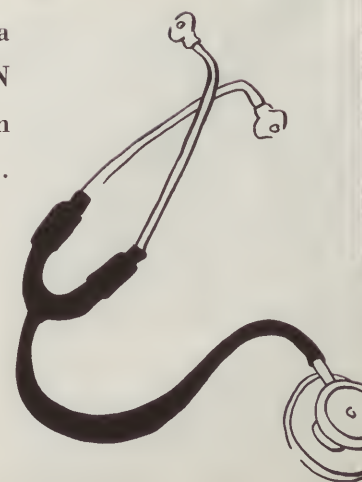
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Balanced Budget Act eliminates Medicaid copay requirement

LITIGATION: New provision may influence outcome of lawsuit against state. BY JANE ZENTMYER

[WASHINGTON] Disagreement over whether states are responsible for the 20 percent copayment for services and items used by low-income Medicare patients has led to litigation against Illinois and other states. But the recently enacted federal Balanced Budget Act of 1997 ended the debate by clarifying that states don't have to pay the 20 percent if the federal rate for a particular item or service exceeds a state's rate.

The new provision became effective Jan. 1 and codifies a position the U.S. Department of Health and Human Services has taken since 1971, according to court records. The clarification of the Medicare law was needed, HHS said, because four U.S. Courts of Appeals had rejected the HHS interpretation of the law. HHS explained in court documents that "Congress expressed its view that the payment rules set forth in [the budget act] are the same as those set forth in prior enactments."

The clarification comes as another federal court, the 7th U.S. Circuit Court of Appeals, considers appeals in a lawsuit against HHS and the Illinois Department of Public Aid. Paramount Health Systems Inc., a Morton Grove distributor of enteral feeding supplies, originally filed suit in 1995, seeking full reimbursement for supplies it provided to Medicare beneficiaries in nursing homes. "A provision of the budget act may resolve this case in the state's favor by allowing the use of the rates of Medicaid, rather than Medicare, for cost-sharing," said an IDPA spokesperson. Although a lower court ruled in favor of Paramount, the state and HHS now say the budget act provision should apply retroactively to the Illinois lawsuit.

The case focuses on the 20 percent reimbursement for Medicare Part B services or items provided to certain low-income elderly patients who qualify for both Medicare and Medicaid. To receive federal Medicaid funds, the state must pay the Medicare Part B premiums and deductibles for these dually eligible patients, according to Paramount's suit. The company complained that the state never paid its 20 percent of the bill because it unlawfully based the payments on Medicaid rates, not Medicare rates.

For example, if the Medicare-approved rate for a particular Part B service is \$100, Medicare automatically pays 80 percent, with the remaining \$20 billed to the patient. For dually eligible

patients, providers like Paramount send that bill for \$20 to Medicaid. When reviewing the claim, Medicaid may deny payment if its fee schedule values that service at only \$50 - \$30 less than what the provider has already received.

A lower court judge ruled that the

law governing Medicare and Medicaid clearly requires states to pay the entire amount of Part B cost-sharing on behalf of all dually eligible recipients. But on appeal, state and federal officials argued that the budget act provision eliminating the copayment requirements is retroactive and precludes them from reimbursing Paramount.

Paramount responded that it is unconstitutional for the provision to be applied retroactively to the judgment. "Now that the goods and services have been rendered at rates that the secretary determined to be reasonable, the secretary requests the court to uphold what

amounts to a retroactive pay cut," according to a reply brief filed by Paramount. The company has lost nearly \$2 million since 1990, said attorney Mark Bereyso of the Chicago law firm Levenfeld, Eisenberg, Janger & Glassberg.

In a supplemental brief, IDPA and HHS argued that Congress acted rationally by making the law retroactive, because it resolves an ambiguity in the statute. According to the brief, "The retroactivity conforms the law to the states' expectations, which were formed by the secretary's long-standing construction of the Medicaid act and by her approval of state plans adhering to that construction." ■



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REPORT for Illinois Physicians

BlueChoice Cesarean Section QI Project

Maternal and neonatal care are important determinants of the health of any population. Outcomes of such care are more definable than for many other conditions. One of the most intensely studied aspects of pregnancy outcome has been the utilization of Cesarean section (C-section). From a national C-section rate of 5.5% in 1970, the rate peaked at 24.7% in 1988 and has not shown a significant decline over the 8 following years. Additionally, although studies have failed to demonstrate an improvement in neonatal outcomes related to increased C-section rates, maternal morbidity and mortality as well as cost are higher for C-section than for vaginal delivery.

In 1980, the National Institute of Health held a conference to explore this topic. At that time, the national C-section rate was 16.5%. The conference identified three factors which appeared to be leading to an increasing rate: the practice of doing elective C-section when there is no prior section history, the declining frequency of vaginal breech delivery and the increasing frequency with which physicians diagnosed fetopelvic disproportion. Additionally, with the average age of women giving birth increasing, maternal age has been identified as an independent Cesarean delivery risk factor.

The Department of Health and Human Services has considered data such as the above and established a number of health promotion and disease prevention objectives termed Healthy People 2000. The Cesarean delivery objective is to reduce the overall national rate to ≤15% including a primary section rate of ≤12% and a vaginal birth after Cesarean delivery (VBAC) rate of ≥35%.

BlueChoice, the point-of-service product of BlueCross BlueShield of Illinois, has addressed this area of care quality since 1992. At that time, the overall C-section rate was 23.8%. Through the second quarter of 1997, the rate had gradually declined to 14.6%. In 1995, the most recent year of complete comparative data, the POS rate for our region was 22.1% compared to a BlueChoice rate of 18.6%.

We have employed several strategies to assist our physician network in reducing the rate of C-section:

- adopt the American College of Obstetrics and Gynecology (ACOG) guidelines for appropriateness of Cesarean section and for vaginal birth after C-section;
- encourage member education regarding VBAC through brochures offered to practitioners and enrollees and a video offered to medical groups, physicians and hospitals;
- assignment of practitioners to reimbursement tiers based on hospital-documented C-section rates;
- provide the consultative services of the Cesarean Section Appropriateness Collaborative to local hospitals.

The above strategies recognize the importance of the physician's involvement in the active management of labor, the implementation of standardized protocols for care management, the education of health care consumers, feedback to physicians regarding their performance and the establishment of the reduction of the rate as an institutional priority. Further information regarding any of the above is available by contacting the BlueChoice Medical Director at (312) 653-8435.

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EDITORIAL

Life after the Blues

The decision by Blue Cross and Blue Shield of Illinois to end its contract with Medicare should come as no surprise. After all, its work with Medicare was usually "low margin, high risk," according to the Blues, hardly a natural fit for a company with a primary interest in building its share in the high-dollar managed care market.

The task was daunting enough: processing more than 66 million Illinois and Michigan claims a year, checking each one for appropriateness and watching for fraud and abuse within the system. And as the years wore on and the focus on health care fraud intensified, the role of the Medicare processor became more challenging than ever. After 31 years, the Blues decided it was enough. The Illinois carrier wasn't the only one to make this decision in recent memory; four other organizations relinquished their jobs as Medicare carriers in the last year.

Although change can cause apprehension, it can also lead to worthwhile re-evaluation, and this situation is ripe for it. Certainly, physicians who regularly deal with the Illinois Blues have reason for concern. After all, many practices have developed relationships with representatives of the carrier who know how to handle problems in this complex system. Even if the new carrier steps in with many of the same people who had worked for the Illinois Blues – not unheard of in the managed care market – there's always a rocky period

of adjustment.

At the same time, a new carrier might pick up where the Illinois Blues left off, stepping in with new ideas for ways to handle a task that's being made more difficult in the wake of new attention on fraud and abuse and the public's growing concern with administrative red tape and the related costs.

Officials of the U.S. Health Care Financing Administration have said they would prefer a contractor with Medicare experience and the ability to take on a substantial workload. Those are good goals. It is also imperative that the new carriers have considerable experience with high-risk claims and a commitment to processing claims and reimbursing physicians on a timely basis. The selection process should also give serious consideration to an Illinois company, because working with an out-of-state carrier can be cumbersome for a physician's office. It's also good to have a nearby carrier so that local physicians – and ISMS – can have a better opportunity to bring up concerns in a more timely manner.

Even though the contract officially ended Dec. 31, the Blues agreed to continue processing Illinois claims until another carrier is in place, probably within the next nine months. In the meantime, ISMS' Third Party Payment Processes Committee will continue to work with the carriers and bring any transition concerns to HCFA's attention.

PRESIDENT'S LETTER

Get ready for a challenging year

Jane L. Jackman, MD



It is becoming apparent that we must turn our attention not only to legislative races but also to judicial elections.

I hope the holidays gave you a brief respite. We need to be well rested and prepared for the challenges that lie ahead this year. The medical agenda for 1998 – both in public policy and medical practice changes – seems so gargantuan that this year again promises to be a tumultuous one. The following are some issues we'll need to tackle.

Tort reform – One week before Christmas, the Illinois Supreme Court, in a Grinchlike frame of mind, struck down the entire 1995 lawsuit reform legislation. For our patients, this law was designed to make health care more affordable and available. Obviously, they are the real losers in this outrageously skewed judicial decision. Our patients will bear the brunt of medical cost increases and access problems. For doctors, the decision means increases in medical malpractice insurance premiums after a two-year moderating trend.

The Illinois Supreme Court overstepped its authority when it ruled on the constitutionality of new laws by setting public policy, which is the job of our Legislature. Yes, it's easy to get discouraged after 20-plus years of work on tort reform, but we need to look at this decision as a temporary setback. Tort reform is just too important an issue to let slip through our fingers. Doctors must have affordable insurance, and we need more fairness in the courts. It is becoming apparent that we must turn our attention not only to legislative races but also to judicial elections. The Texas Medical Association achieved its tort reform by doing just that. We should take note!

Managed care legislation – Despite its poor image with the public, managed care continues to grow in Illinois because of its potential to moderate medical costs. Many patients and their families, though, are asking their legislators to regulate managed care entities after receiving what they perceived as shoddy treatment from their HMOs. Last year, the Illinois House passed H.B. 626, which contained most of the patient protections found in our own Managed

Care Patient Rights Act. The Senate held managed care hearings all over the state last summer and fall and is expected to craft its own legislation this spring. We can all help support the passage of some of the provisions of MCPRA by telling our state senators about what we've experienced with managed care and why our patients need legislative protections. Quality shouldn't be sacrificed simply for cost containment.

APRN scope of practice – Advanced practice registered nurses – including certified nurse midwives, clinical nurse specialists, registered nurse practitioners and certified nurse anesthetists – are an important part of the medical team. In several areas of the state, they have proved themselves to be invaluable in extending physician care to more patients. They should be recognized under statute but should not practice independently from physicians. Just as physicians should practice within their sphere of competence, APRNs should practice according to their training and experience. That is best achieved through a collaborative and interactive practice between physicians and APRNs. Last month, ISMS produced a white paper on the licensure of APRNs, which is well worth reading. It is in our patients' best interest to have the Illinois Nurses Association and ISMS agree on the language of any bills that define APRNs' scope of practice and licensure.

November elections – Yes, it is an election year again! Despite all the political rhetoric, we have a legitimate interest in getting friends of medicine elected in 1998, since medical practice is more and more determined by our Legislature. Get involved in the campaigns, be sure to vote and give generously to IMPAC.

Dealing with these issues will take hard work by an informed and active membership and Medical Society, with the skills and resources to measure up to the challenges. I hope we can look to all of you for support in the coming year.

GUEST EDITORIAL

Managed care formularies can be a real headache

By Wendy S. Viitala

It's a pain when your insurance company gives you a blistering migraine while denying coverage for your migraine medication, but that's what happened to me. Because my migraines had increased to the point that they were affecting my care of my two youngsters and my work, I'd seen my primary care doctor. He prescribed two medications: a beta blocker to help prevent migraines and a drug to take when a migraine occurred. He also prescribed an allergy medication for unrelated ailments.

"Bad news," said the pharmacist when I stopped by to get the prescriptions. "Your insurance company won't pay for any of this stuff." Aetna U.S. Healthcare demanded that I get generic substitutes for the migraines and for the allergies – all of which had proved ineffective. At home, I called the number on my insurance card and was met with: "Press 1 for this, press 2 for that." After five minutes in the verbal maze, I heard "all operators are currently busy" and went into the void of on-hold. Then I heard, "If you're experiencing a medical emergency, please hang up and call your physician." Good advice, I thought, as I passed the 10-minute mark, because if I had to wait for you, I'd be dead.

After another five minutes, I reached a person and explained the problem, spelling the names of the medications several times. She put me on hold, then returned with a different telephone number. The second round of button-pushing got me right back to on-hold. On a day off with my children, I really did not want to spend this kind of time on the phone. But what else could I do? I needed the medication, one bottle of which cost \$71, and I expected my insurance company to pay for it.

Finally, another person came on the line. After what I imagined was a check of the medications, she informed me, "You're batting three for three. These medications are not on the formulary."

Not on the formulary. OK, right. That explained it. But what was a formulary? She clarified it rather irritably, and then said in a voice that suggested a second-grade teacher scolding a child for having dirty fingernails: "Clearly, your doctor was not looking at the formulary when he prescribed these."

"I always thought the doctor should be the one to decide which medications to give a patient," I said. After her long silence, I asked about my next step. She testily advised me to call my doctor and ask him to call the insurer.

By then it was late Friday afternoon, and I left a message that my doctor wouldn't get till Monday. I dreaded the weekend. Sure enough, at the forest preserve I was struck with a migraine that gutted my vision, churned my stomach and felled me from the enjoyment of acorn inspection with my family. I spent Sunday afternoon in bed.

On Monday, I called the doctor from work. He sighed a lot; I knew he'd been here before. He and his secretary and I spent the day calling Aetna and one another. Finally, at about 4:30 p.m., the doctor reported that Aetna had approved all three medications. He had a fax from the insurer indicating approval, and he put it in my file.

The next morning when I went to get my medications, the pharmacist tapped into his computer three times before pronouncing, "They're still denying coverage."

I went home to call my doctor. His secretary found the approval fax, and I called the insurance company. Again there was interminable button-punching, then hold, before I reached Louis.

Poor Louis just kept telling me that coverage was denied, according to the computer. "But my doctor has the fax from someone in your company approving the payment for all three medications," I said. Louis would not budge. By then, I was not a patient patient. I wanted my medication, and I wanted my insurance company to pay for it. It had

Dates for Annual Meeting, resolution deadline set

Mark your 1998 calendar: The ISMS House of Delegates Annual Meeting will be held April 24-26 at the Oak Brook Hills Hotel at 3500 Midwest Road in Oak Brook.

County medical societies should send a list of delegates and alternates to ISMS headquarters before Jan. 31. All delegates and alternates will be notified of the meeting through an official meeting call.

Only delegates and voting members of the House of Delegates may submit resolutions. Resolutions must be received at ISMS headquarters before the close of business on March 24; a March 24 postmark is not sufficient. After that date, resolutions will be con-

sidered late and will be reviewed by the Committee on Rules and Order of Business to determine whether the house should consider them.

Resolutions should be addressed to Speaker of the House of Delegates John Schneider, MD, Illinois State Medical Society, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602. The ISMIE Annual Meeting is scheduled for April 22 at the Oak Brook Hills Hotel.

Informational materials and meeting packets for the ISMS Annual Meeting will be mailed to members of the house and county medical societies on March 25. For more information, call (312) 782-1654 or (800) 782-ISMS.

been six days, one small migraine and one walloping migraine since my doctor had prescribed it, and I was filled with rage that I tried not to unleash on Louis. (And as any migraine-sufferer can tell you, suppressed rage is not a good thing.) Finally, Louis gave me another insurance company number.

I groaned as I hung up and redialed. I'd been on the phone with Louis for 20 minutes, and I braced myself for more of the same. The next person seemed a bit more sympathetic. "Just tell me what I can do to expedite getting my medicine. It's been six days," I pleaded. After a while, he acquiesced to my idea: My doctor could fax to the insurance company the papers he'd been sent by the insurer to prove the company had approved payment for the medication. He gave me a fax number, and I called the doctor's secretary and explained the situation.

Then I did something that five years of motherhood – with sleepless nights and kids' sickness, whining and fits – had not led me to: I poured a glass of wine to calm down. Later, I heard from the pharmacist, who had also been on the phone with the insurance company:

Aetna had agreed to pay for the medication, and I could pick it up.

I'd like to say that this was the end of the problem. But the next month when I needed refills, Aetna again denied coverage. My pharmacist wrangled with Aetna for 20 minutes before I gave up and went home. The pharmacist called later to say the insurance company had found the approval papers, so I picked up my prescriptions and got another surprise. The medication that had cost \$7 last month now cost \$21. This kind of discrepancy happens frequently, the pharmacist said, adding his theory that the copayment depended on who was doing the approving and what they felt like charging. He said I could probably get the copayment lowered, but I was too weary to wage that battle.

These days, I get almost punchy at the end of the month, anticipating a fight to refill my medication. A friend refers to the insurer as the "just say no to coverage" company. My pharmacist is more direct: "All companies are like that now. Nobody cares about the patient."

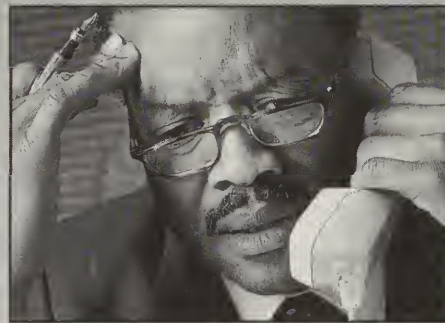
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Assisting in suicide not our role, physician says

CONFERENCE: Debate focuses on state physician-assisted suicide bill. BY LINDA MAE CARLSTONE

[CHICAGO] "I do not want my patients wondering if I'm there to heal them or to kill them," said Craig Backs, MD, who represented organized medicine's viewpoint on physician-assisted suicide at the Governor's Conference on Health and Aging held Dec. 5 in Chicago. As an internist who cares for the elderly and the dying in his Springfield practice, Dr. Backs raised the concern

that legalizing physician-assisted suicide could be the first step toward pushing poor, elderly and disabled patients to their death.

But it was Dr. Backs the family man who told a personal anecdote. "My wife and I took care of my dying mother-in-law and sister-in-law in their final days," Dr. Backs told the audience of lawyers, physicians, social workers and nursing-

home caregivers. The physician-assisted suicide issue hit home when his mother-in-law's morphine pump malfunctioned and the pain became too much for her to bear, he said. She whispered the name of well-known suicide assistant Jack Kevorkian, MD, a signal that she wanted to speed up her own death. "But then we got the



Dr. Backs

morphine pump working, and the request went away," Dr. Backs said.

Physician intervention to honor a request to accelerate the dying process is against the law in Illinois. The debate during the conference centered on H.B. 691, a bill that would establish procedures to help competent terminally ill people hasten their death through medical assistance. The bill is being considered by the Illinois House Judiciary Criminal Law Committee.

"Under the bill we could say, 'Let's not waste any time. Let's get this over with,'" said Dr. Backs, who is a member of the ISMS Governmental Affairs Council and spoke on behalf of the Society. The urge to hasten death is a reflection of a society that wants things now, he said. "We don't want to wait, and we don't want to deal with any pain or suffering." That reaction is human nature, but the consequences are not worth the gain, he said.

John Cirn, a founder of the Illinois Citizens for Death with Dignity, argued that Illinoisans should have the right to determine whether their lives still have meaning. "No one else should be the judge of whether his or her suffering is unbearable." The public supports physician-assisted suicide, Cirn added, pointing out that Oregon recently legalized it.

Dr. Backs responded that the Oregon law is an aberration, not a trend. "If you look across the country at legislative activity regarding physician-assisted suicide, 35 states have prohibited it by statute, nine have prohibited it by common law, and two states rejected referendums promoting the issue."

Dr. Backs said society would be placed on a slippery slope if physicians were allowed to help patients die. Because of concerns about cost containment, laws could be used to legalize the removal of the most vulnerable members of society, such as the elderly, the disabled and the uninsured — all of whom cost taxpayers a lot of money, he said.

Cirn said the proposed legislation includes 13 pages of safeguards against abuse. For example, dying patients would be required to request suicide assistance several times for at least two weeks, and a second physician would need to confirm the request before assistance could be given, Cirn said.

"There's no good reason why dying patients who meet the qualifications spelled out in the [bill] should be denied access to the best medical science can offer to achieve relief," Cirn said. Dr. Backs responded that his experience has taught him that patients don't always say what they mean. "Patients talk in code. Even with advanced directives in writing, their directions can be vague."

Instead of resorting to suicide assistance, the medical profession must retool its efforts to provide adequate treatment for pain and anxiety, especially when a disease can't be cured or even controlled, Dr. Backs said. Patients need assurance that they won't be abandoned by their physicians. He conceded that physicians could be better prepared to deal with dying people.

In June 1997, the U.S. Supreme Court ruled that physician-assisted suicide is not a right, but the decision doesn't preclude states from legislatively allowing the practice. ISMS, along with 50 other groups, joined the AMA in filing an amicus curiae brief opposing the legalization of physician-assisted suicide. ■

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ISMIE Update

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High court rules on statute of limitations for minors

DECISION: Justices uphold the exception for legal disabilities. BY LINDA MAE CARLSTONE

[SPRINGFIELD] An Illinois Supreme Court ruling on a malpractice lawsuit filed 16 years after the alleged negligence occurred could reverberate through future cases involving the statute of limitations for minors. In *Bruso vs. Alexian Brothers Hospital, et al.*, the high court ruled Oct. 2 that the claim of negligence at the birth of Brian Bruso in 1976 was not barred by the eight-year statute of limitations on minors filing malpractice claims.

In its ruling, the court applied an exception that extends the limitation indefinitely if the plaintiff is legally disabled. That exception has always been on the books for those who suffer from disabilities that cause incompetence in decision-making, according to ISMS General



Counsel Saul Morse. But this case marked the first time the Supreme Court addressed the issue directly since a 1987 amendment supported by ISMS set the statute of limitations for

minors at eight years after an incident occurred, he said. Before 1987, the four-year statute of limitations to file a claim began running at an individual's 18th birthday. So, any claims related to medical negligence that occurred between a child's birth and 18th birthday could be brought until the plaintiff turned 22.

With the 1987 amendment, the point at which the statute began running changed from the plaintiff's 18th birthday to the time of the negligent event.

In analyzing the 1987 amendment, which was supported by ISMS, the court found that the Illinois Legislature intended to create three separate statutes of limitations, Morse said. The first, for adults, is two years from the

time a person knew or should have known about the alleged negligence but no more than four years from the occurrence. The second statute, for minors, was eight years from the occurrence. The third, which existed before 1987, provides that in cases of legal disability – involving incompetence in decision-making – the statute of limitations is extended indefinitely.

The law has long held that if an individual lacks the capacity to understand, statutes of limitations are extended indefinitely, Morse explained. But in the *Bruso* case, the defendants argued that the legal disability provision could apply only to negligence experienced by adults. The court responded that when the Illinois Legisla-

ture created the eight-year statute for minors, it didn't change the existing law covering legal disabilities.

Morse said the high court's unanimous decision isn't surprising, but it raises a concern that the legal disability limitation could be abused. "We will have to make certain that the alleged legal incapacity or lack of mental competence occurred as a result of the alleged malpractice or was in existence based on medical evidence at that time."

It is too soon to know about the ruling's impact, Morse said. "We won't know for several years if we will get cases on behalf of 10- and 12-year-olds. But we will have to look at these cases closely to know if there truly is a legal disability." ■

Plaintiff attorney suspended for backdating postage meter

LEGAL ABUSES: Attorney ordered to repay ISMIE for legal fees. BY JANE ZENTMYER

[CHICAGO] The license of a DeKalb plaintiff attorney was suspended for one year after the Illinois Attorney Registration and Disciplinary Commission found he backdated a postage meter stamp to file a late appeal in a challenge to the dismissal of a case against two ISMIE-insured physicians.

"For years, physicians have asked us why we don't do something about what they regard as shady lawyer practices," said Chairman of the ISMIE Board of Governors Harold Jensen, MD. Although physicians tell ISMIE about those practices, it isn't always possible to seek discipline against plaintiff attorneys. But "we do hear [our policyholders]. We do agree there's a problem, and whenever we can, we'll try to take actions like this."

In this instance, ISMIE authorized its defense attorneys, Eugene Doherty of Holmstrom & Kennedy P.C. in Rockford and David Faulkner of Lord, Bissell & Brook in Rockford, to

request the dismissal of an appeal based on the conduct of plaintiff attorney Robert Steven Wilson. When the 2nd District Court of Appeals in Elgin dismissed the appeal, it ordered Wilson to reimburse ISMIE for about \$33,000 in legal fees. The defense attorneys also reported Wilson's actions to the Attorney Registration and Disciplinary Commission.

Wilson filed a medical malpractice lawsuit in 1987 in the Winnebago County Circuit Court in Rockford against two ISMIE-insured physicians and two hospitals. In September 1993, the judge dismissed the case because Wilson failed to reply to discovery requests, according to a report from the disciplinary commission.

After the judge's decision, Wilson filed an appeal in the 2nd District Court of Appeals, according to the report. For this case, the notice of the appeal was due by Oct. 23, 1993. Wilson missed the first filing deadline, and the court clerk entered an order that set a final due

date of Feb. 28, 1994. Wilson testified that the notice and the brief were mailed from his Sycamore law office on the dates of the deadlines and postmarked accordingly by his firm's private postage meter.

But the Carol Stream post office, which handles mail from Sycamore, replaced the private postage stamps with its own.

The notice of appeals had an Oct. 27 postal stamp, and the brief bore a March 15 postmark. The disciplinary commission's report includes testimony from the Sycamore postmaster about the postmark process: "Mail that bears a private postage meter stamp and that has a proper date on it is not postmarked by the post office. However, if the private meter stamp bore the wrong date, the letter would normally be over-stamped or 'canceled' with a Carol Stream postmark."

The disciplinary commission found that the evidence proved several charges against Wilson, including: conduct that tends to defeat the administration of justice or to bring the courts or the legal profession into disrepute; making a statement of material fact or law that the lawyer knows is false while he appears in a professional capacity before a tribunal; conduct involving dishonesty, fraud, deceit or misrepresentation; and conduct that is prejudicial to the administration of justice. ■

MALPRACTICE ROUNDUP

Hysterectomy, oophorectomy were appropriate care, jury finds

A California jury found that on the basis of a patient's medical history, a surgeon acted within the standard of care by performing a hysterectomy and bilateral oophorectomy, according to the October edition of *Medical Malpractice Law & Strategy*.

In *Siudym vs. Tarzy*, the patient had a long history of endometriosis, experienced abdominal pain and stress incontinence and had a large fibroid in her uterus. The surgeon wanted to perform a laparoscopy, but the patient wanted a curative procedure. So, after obtain-

ing the patient's consent, the physician instead performed a hysterectomy and oophorectomy.

The patient later alleged the surgeries were unnecessary and her symptoms were related to undiagnosed gastrointestinal disease. She also said she was suffering from emotional distress and injury from a suture in her bladder that had to be removed surgically.

The physician responded that the surgeries were consistent with the patient's history and that the suture in the bladder was a known complication.

Physicians and advanced practice nurses square off on scope of practice

Disagreement centers on prescriptive authority

BY JANE Z



Changes in the delivery of health care, especially the growth of managed care, are transforming the traditional roles of physicians and allied health professionals. In New York, for example, Oxford Health Plans launched a pilot project that pays nurse practitioners to provide physician services at physician rates. Here in Illinois, the debate on the state licensure of advanced practice nurses has reignited and is expected to continue during the 1998 legislative session.

Last summer, ISMS and the Illinois Nurses Association negotiated on statutory changes in the scope of practice for advanced practice nurses, but there have been some misconceptions about that negotiation. At its Nov. 12 lobby day in Springfield, the INA distributed fliers stating, "The APRN Task Force has made considerable movement from its original positions. The ISMS positions have moved only in the opposite direction."

M. LeRoy Sprang, MD, chairman of the ISMS Board of Trustees, said that in fact, "ISMS has moved dramatically over the last year or two from its previous positions, which were much firmer." The Society previously opposed granting prescription-writing authority to advanced practice nurses but now supports delegated prescriptive authority for Schedule III to V drugs. "We have made significant strides, and others have been impressed by our flexibility," Dr. Sprang said. "Now, it's just a matter of whether the other side is willing to move toward the middle."

To ISMS, the cornerstone of the relationship between a physician and an advanced practice nurse should be a collaborative agreement. That agreement, developed by a physician and an advanced practice nurse, would govern how a collaborative practice works, according to Joan Cummings, MD, chairman of ISMS' Council on Education and Health Workforce and of the ad hoc subcommittee on advanced practice nurses. "This written agreement defines how they will [set up] this practice whereby the patient gets the benefits of both professionals, and it defines the scope of practice in terms of what the patients will be responsible for."

Some advanced practice nurses agree that a collaborative agreement is necessary but think the specifics shouldn't be legislated. "The collaborative agreement must be individual between every advanced practice nurse and physician or physicians," said Rosemary Meganck, a certified nurse midwife and a member of INA's advanced practice task force. "Those things should not be mandated by law. To do so assumes that neither profession is capable of making a professional decision on its own without a law."

ISMS President Jane Jackman, MD, said that to ensure the agreements result in a truly collaborative practice, the law must include certain basic details. For example, it should state that an advanced prac-



tice nurse's scope of practice should be limited to the collaborating physician's scope of practice, so a nurse midwife could have an agreement with an Ob/Gyn but not with a cardiologist, Dr. Cummings said. But other specifics — such as the procedures that require a physician's presence and the communication methods used for immediate consultations — should be left to the physician and the advanced practice nurse, Dr. Jackman said.

The INA, however, opposes "limiting the advanced practice nurse's scope [of practice] to that of a backup physician," Meganck said. "That's a sticking point because the Medical Society insists that that be the case." Limiting the scope of practice decreases patients' access to care, she said, and in some ways it insults physicians and nurses because it assumes they can't make professional decisions on their own.

Dr. Cummings said there is no concrete proof that limiting advanced practice nurses' scope of practice will reduce access to care. Just as it doesn't make sense for a neurologist to provide care to a woman who needs Ob/Gyn services, it doesn't make sense for a neurologist to have a collaborative agreement with a nurse midwife who may provide some Ob/Gyn services. A collaborative arrangement expands the care given to patients, because they have access to a highly trained team, she added. "The collaborative agreements are necessary to understand what the roles of the team members are."

Elizabeth Burns, MD, a family physician who represents the Illinois Academy of Family Physicians on the ISMS ad hoc subcommittee, collaborates with

anced practice nurses ope of practice

collaborative agreements and ratios.

TMYER



Patrick Whelan

nurse practitioners in her practice. Those nurse practitioners can spend more time educating patients while physicians focus on acutely ill patients or others, she said.

ISMS also supports a ratio for the number of collaborative agreements a physician can have with advanced practice nurses. A physician can have collaborative agreements with two such nurses or their full-time equivalent, according to ISMS policy. An anesthesiologist can have agreements with four nurse anesthetists or their full-time equivalent. But INA opposes these ratios. "They impose needless restrictions on both the professions of nursing and medicine and in the long run will decrease access to care," Meganck said.

But ratios are necessary to ensure that collaborative agreements work, Dr. Burns said. "The rationale is if you are going to collaborate, you need to have a small enough number [of agreements] so you actually know what each person is doing and that they are practicing together."

Another ISMS policy change grants delegated prescriptive authority for Schedule III to V drugs to advanced practice nurses within the collaborative practice setting. But INA contends that prescriptive authority should not be delegated by a physician and that it inconveniences the patient, limits access to health care and places an unnecessary burden on physicians and nurses, according to Meganck.

The delegated prescriptive authority has its roots in collaborative practice and should be based on the predetermined role of each team member. Dr. Cum-

(Continued on page 10)

How education and training stack up for nurses vs. physicians

Advanced practice nurses

- Registered nurses prepare for licensure in one of three ways: associate degree programs in two-year community colleges, hospital-based diploma programs ranging from two to three years or four-year bachelor of nursing programs.
- Completion of advanced practice nurse programs takes from nine months to two years. Advanced practice registered nurse certification is available to RNs regardless of which program they completed, but most APRN certification programs require at least two years of clinical practice.
- RNs can become certified as advanced practice nurses by passing a written examination offered by one of several nursing specialty organizations or as part of a stand-alone or graduate degree program.
- Graduates of all Illinois advanced practice nursing certification programs earn a master's degree. APRNs who were educated in other states can still practice here without a master's degree.
- Professional organizations recommend only 10 hours of continuing education units annually.

Physicians

- After earning a bachelor's degree, students complete four years of medical school, which includes 150 to 200 class hours of work related to interviewing patients and conducting physical exams, 111 formal hours of basic pharmacology and two or more years of clinical experience.
- After medical school, two years of residency is required for unlimited license eligibility.
- Students who specialize in family practice or internal medicine must have an additional three years of residency training. Anesthesiologists must have an additional four years of training, and Ob/Gyns must have at least four additional years of training.
- After residency, most physicians pursue board certification as another independent assessment of competence.
- Illinois' Medical Practice Act requires 50 hours of CME annually.

Source: ISMS Position Paper on the Licensure of Advanced Practice Registered Nurses

Physicians

(Continued from page 9)

mings said that "in the written agreement, you define the scope of what kinds of things [advanced practice nurses] are going to do. It would mean, for example, that nurse midwives would not be going out prescribing antihypertensive and congestive heart failure drugs, because it's not within the scope of that written agreement and within the scope of practice. They would be prescribing [drugs] for the patient that fall within the realm of their training and skills."

The differences in education and training define the practice of medicine vs. nursing, according to John Schneider, MD, president elect of the Illinois Society of Internal Medicine. At a minimum, a physician's education includes four years of undergraduate education, four years of medical school and a three-year residency. "If you're going into a specialty, it's very easy to see that there is a base that you build upon, and you gradually branch off [into other areas]. That's not as clear when you look at the training of advanced practice nurses." Physicians may apply for their medical licenses after eight years of education and two years of residency training. Certification for advanced practice nurses can take from about three years to six years.

Meganck noted that there are some things advanced practice nurses can't do. "That's why it's important to have a physician that you can consult with and that you give referrals to — just like a

family physician who refers to the orthopedic surgeon when a patient requires orthopedic surgery. An advanced practice nurse would like to have a relationship with a physician who has a wider scope of practice so that when a patient comes along that's out of the scope of practice of an advanced practice nurse, that nurse can refer to the correct specialist."

ISMS doesn't support the independent practice of medicine by nurses. "They can certainly practice nursing totally outside of this collaborative arrangement," Dr. Cummings explained. "The issue is when they practice things that for all intents and purposes appear to be the practice of medicine. Diagnosing illnesses and treating them with drugs is the practice of medicine. When, with their training, the [advanced practice nurses] move into that arena, that's when this collaborative relationship should kick in."

Although ISMS and INA haven't agreed on the details of licensure for advanced practice nurses, Meganck said a bill will be introduced during the spring session that represents INA's policy. ISMS will keep abreast of these events and continue negotiations, Dr. Sprang said. "We do want to work with them, and obviously many physicians have an ongoing relationship [with advanced practice nurses], so this is a positive thing. We just want to make sure that there is an appropriate balance between what the person is doing and his or her education, background and experience." ■

Deadline for Medicare decision extended

[CHICAGO] Physicians have until Feb. 2 to decide whether they want to be 1998 Medicare participants thanks to a one-month extension the U.S. Health Care Financing Administration announced in December. HCFA said it extended the deadline because of all the changes to Medicare included in the Balanced Budget Act of 1997.

Physicians, practitioners and suppliers who agree to participate in Medicare must accept assignment for all covered services.

Physicians who want to maintain their current status as participants or

nonparticipants do not need to take any action. Those who want to

change their status to become participants should complete the participation agreement sent in early December and return it to the Illinois carrier, Blue Cross and Blue Shield of Illinois. Physicians who participated in 1997 but don't want to continue to participate this year must notify the carrier of their decision in writing by Feb. 2.

For more information about Medicare participation, physicians may call the Medicare Part B Provider Certification office at (618) 993-4780.



ISMS outlines

(Continued from page 1)

ISMS believes, for example, that APRNs and collaborating physicians must develop the written agreement and sign it. And APRNs may provide services only in the same area of expertise as the physicians with whom they have collaborative agreements.

"The agreement should promote the exercise of professional judgment by the APRN commensurate with his or her education and experience," according to the ISMS paper. "It does not need to spell out the exact steps an APRN must take with respect to each specific condition, disease or symptom, nor must it require the physical presence of the physician at all times at the place where services are provided."

The collaborative agreement must explain which procedures require the physician's presence when they are performed, describe the method of communication for immediate consultation between the APRN and the physician and provide for the physician to appear on-site for consultation at least once a week. However, when a nurse anesthetist provides care, a collaborating physician must take part in choosing the anesthetic and remain present and available for immediate diagnosis or treatment of emergencies.

ISMS supports giving APRNs delegated prescriptive authority for Schedule III

to V drugs and defining the limits of that authority in the collaborative agreement. But the authority to prescribe Schedule II drugs would remain with physicians. The position paper also states that one physician could have a collaborative agreement with the full-time equivalent of two APRNs and one physician could hold a collaborative agreement with the full-time equivalent of four nurse anesthetists.

The ISMS paper states that to be licensed in Illinois, APRNs must have a master's degree in advanced practice nursing and pass a national certifying examination beginning July 1, 2000, or must have 10 years of experience as an APRN before that date. The licensure and discipline of APRNs should be handled by a committee that has significant physician representation and is separate from the Illinois Board of Nursing, the position paper stated.

"We believe that APRNs are an important way of extending care to more patients, and there are certain things that advanced practice nurses excel at, such as patient education and preventive health services," Dr. Jackman said. "But ISMS still has the position that doctors and nurses are different in what they do. They're not interchangeable."

To receive a copy of the position paper, physicians may fill out the business reply card on the cover of this issue. A copy is also available on the ISMS Web site at <http://www.isms.org>. ■

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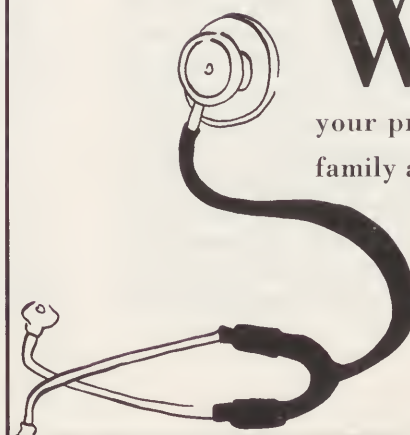
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HCFA extends

(Continued from page 1)

issued, several areas of concern emerged. At its interim meeting in December, the AMA House of Delegates approved resolutions urging actions such as eliminating requirements for excessive documentation; reflecting physicians' added time and expense in processing Medicare payments; ensuring that documentation errors aren't considered fraudulent on their face; and removing documentation requirements that are unrelated to care.

"The AMA will continue to work with HCFA to change some areas that are onerous," Dr. Lewers said. "The AMA has met with HCFA several times in recent weeks, and the specialty societies have joined us to point out some of the problems that have been created."

Dr. Lewers said the AMA advised HCFA only on the development of the guidelines. "Whether or not the advice was accepted is another issue. The AMA did not write [the guidelines]. This is HCFA's document."

Critics of the new regulations say they are excessive and rob physicians of time with patients. "There are only so many hours in a day," said Richard Gamelli, MD, a surgeon at Loyola University Medical Center in Maywood and chairman of the hospital's burn center. "It does nothing to enhance patient care if I'm here until 8 at night generating reams of paper for regulatory requirements."

Another complaint is that the extent of the examination required to charge for a full exam is too broad. Dr. Gamelli said that as a burn surgeon, he often performs sophisticated exams that do not include checking the heart and lungs. "They are not trivial exams, but they would be considered a single-system exam."

The guidelines expand the description of what the codes mean and the correct documentation that applies to the coding, said Douglas Busby, MD, medical director of Medicare Part B of Health Care Services Corp., Illinois' Medicare carrier. "The rules spell out what we expect to see in the record if that code is billed. It's hard to reconcile paying an upper-level code when a physician has written in the record, 'The patient feels fine today.'" A proper match between the code and the actual work performed is more important than ever in light of HCFA's increased emphasis on audits, Dr. Busby said.

The guidelines provide more specifics for physicians about what needs to be documented for E&M services, said James Cuca, a health insurance specialist in HCFA's Chicago regional office. Specialties will no longer be confined to coding specific services into the table for a general multisystem exam, Dr. Busby said. For the first time, documentation requirements have been defined for examinations of 10 different organ systems, including ocular, cardiovascular and neurological, he said. An ophthalmologist or a cardiologist, for example, will use the table identifying the procedures for specific body system exams, he explained.

With heightened interest in fraud and abuse, physicians would be well advised to follow the guidelines, an HCFA spokesperson said. Medicare has indicated there will be prepayment reviews, something that has not been done since

1992, according to an AMA spokesperson. The crackdown is in response to criticism that the agency paid for medically unnecessary services and services that weren't documented in the records, she said.

HCFA is expected to increase the number of random Medicare claim audits it conducts to check for discrepancies between billing and documentation, Dr. Busby said. In an audit, records are pulled and reviewed. During the grace period, either the documentation guidelines developed in 1994 or the new guidelines are acceptable. Future audits of claims submitted during the grace period will be based on whatever guidelines were used on the claim, he said.

Physicians who don't have the time to do their own billing should periodically monitor their billing staff and procedures to make sure the coding is being done properly, said John Schneider, MD, chairman of ISMS' Third Party Payment Processes Committee. The new guidelines won't change how physicians practice, but physicians will need to provide more documentation than in the past, he added. "The detailed documenting will be easiest for physicians who have recently been in school because it is close to what is being taught." Also, physicians should not resort to undercoding to avoid an audit, he said. First, they will be underpaid for their services. Second, it could look to HCFA like they were providing insufficient care. Low charges — much like high charges — will appear to HCFA as aberrant billing patterns and likely will lead to an audit, Dr. Schneider said.

The Documentation Guidelines for Evaluation and Management Services were mailed to every provider who submits E&M claims, Dr. Busby said. The guidelines were also printed in the July edition of CPT Assistant, which can be purchased through the AMA by calling (800) 621-8335; or download guidelines from HCFA's World Wide Web site. ■

Illinois Blues

(Continued from page 1)

choice. "We would certainly want an organization committed to a successful transition. And we will be evaluating in detail the capability of an organization to take on this additional workload."

Medicare Part A and Part B could end up being administered by two different organizations, Collins said. The Blue Cross and Blue Shield Association, a national organization of independent Blues plans, holds the contract for the Part A portion of the Medicare business and subcontracts work to local Blues plans like the Illinois Blues. The association is now looking for another Blues plan to administer Medicare Part A, and HCFA must approve the plan the association eventually chooses, said association spokesperson Iris Shaffer. But HCFA is conducting its own search for a company to pick up the Part B workload, Collins said. The government hasn't decided on its selection process.

The Illinois Blues is responsible for processing 66 million Medicare claims annually from hospitals, physicians and other providers in Illinois and Michigan. In addition to basic claims administration, the carrier will oversee investigations of program integrity, medical reviews of claims and educational efforts for beneficiaries.

John Schneider, MD, chairman of ISMS' Third Party Payment Processes Committee, said the carrier and physicians have a relatively good relationship, so the upcoming changes may trouble physicians. One concern, for example, is that physicians and their staff have developed working relationships with the carrier's employees and know who can help resolve problems. Those relationships must be re-established when a new group begins administering Medicare.

Dr. Schneider said there is also the possibility that "whoever is going to do the Part A and Part B [administration]

may be out-of-state. This poses an additional complication." With the Illinois Blues, physicians have benefited from geographic proximity. "It's easy to call [the Illinois Blues] if you need to talk to people, and it's been easy for ISMS to be able to resolve issues that physicians have brought up."

The Illinois Blues has said it will help make the transition as seamless as possible for Medicare beneficiaries, according to Kieckhefer. About 1,200 employees work on the Blues' carrier business. Because of the long transition period, the company hopes to keep as many employees working as possible, he said. Those employees may also end up with the new carrier, Kieckhefer said. For example, when the Illinois Blues took over the Michigan carrier's responsibilities three years ago, its contract required that it also take over the Michigan office and most of its employees. ■

Physician HELpline

ISMS' 24-hour Physician HELpline is available to link impaired physicians and their families with helpful resources.

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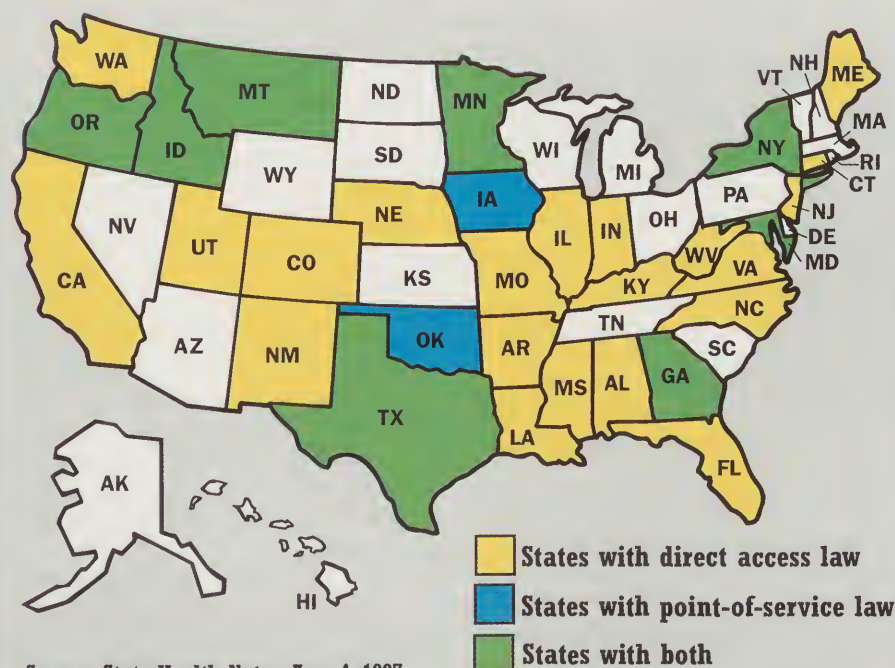
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State legislatures manage managed care

Twenty-nine state legislatures have passed laws to allow managed care patients to designate Ob/Gyns, dermatologists and other specialists as their primary care physician. In addition, 10 states have enacted point-of-service laws allowing managed care patients to go out-of-plan for care if they pay more out-of-pocket.



Tort reform

(Continued from page 1)

Harold Jensen, MD, chairman of the ISMIE Board of Governors, said Justice Benjamin Miller, who cast the only dissenting vote, "was the only justice who understood the Supreme Court's proper role."

**Justice Benjamin Miller
"was the only justice who
understood the Supreme
Court's proper role."**

Miller wrote that the court attempted to set public policy with its ruling. "Today's decision represents a substantial departure from our precedent on the respective roles of the legislative and judicial branches in shaping the law of this state," he wrote. "Stripped to its essence, the majority's mode of analysis simply constitutes an attempt to overrule by judicial fiat the considered judgment of the Legislature."

At the core of the court's 98-page decision was its conclusion that the \$500,000 cap on noneconomic damages was unconstitutional. The cap was special legislation, the court ruled, because it failed to acknowledge that plaintiffs have different injuries and may deserve different levels of compensation. "We do not disagree with the defendants' assertion that damages for noneconomic injuries are difficult to assess," wrote Justice Mary Ann McMorrow on behalf of the five-member majority. "We simply determine that it does not follow that the difficulty in quantifying compensatory damages for noneconomic injuries is alleviated by imposing an arbitrary limitation or cap on all cases without regard to the facts or circumstances." But the decision conceded the difficulty in assessing noneconomic damages, a problem that ISMS and ICJL pointed out before the law was passed.

The majority also struck down the \$500,000 cap on the basis that it violated the separation of powers doctrine. The court reasoned that the cap infringed on the judiciary's power to

determine whether a verdict was excessive and to reduce it accordingly. "The courts are constitutionally empowered and, indeed, obligated to reduce excessive verdicts where appropriate in light of the evidence adduced in a particular case," McMorrow wrote. The cap, however, "reduces damages by operation of law, without regard to the specific circumstances of individual jury awards."

But Miller pointed out that "the challenged provision does not represent a finding about the evidence of any particular case, and it does not detract from the power of the court to reduce an award of damages in appropriate circumstances."

Once the justices disposed of the cap, they addressed the law's elimination of joint and several liability, which was intended to prevent plaintiffs from chasing deep-pocket defendants. The 1995 law made defendants liable to pay only the portion of the award that corresponded to their level of fault. But the law included a provision that reinstated joint and several liability in medical malpractice cases if the court ruled the cap invalid. Justices said this exception made the reform unconstitutional because it applied to only one class of personal injury plaintiffs.

**"It is once again open
season on businesses,
doctors, hospitals, local
taxpayers and not-for-
profit organizations."**

The court also struck down product liability reforms and affirmed an earlier decision that changes made to the Petrillo doctrine were unconstitutional. These reforms, in addition to the cap and the elimination of joint and several liability, were the centerpiece of the law, the court said. After examining how the General Assembly passed the reform, the court concluded the Legislature meant for the law to stand or fall as one piece. Since the key provisions were unconstitutional, the court reasoned, the entire law must be thrown out.

**Tort reform opponents
tried to persuade
justices to "play
legislator" from the
moment the law was
passed, and they seem to
have succeeded.**

The court often tries to maintain as much of a law as it can by separating provisions and upholding whatever portions it can, according to ISMS General Counsel Saul Morse. But by ruling the entire law invalid, the court didn't have to consider other tort reforms such as the required identification of physicians who review cases and certify their merit. ■

Call to action

Last month, officers from ISMS, ISMIE and ISMIS sent members a card urging them to take action in response to the Illinois Supreme Court's decision to overturn the 1995 tort reform legislation. This is what they said physicians can do to help regain the hard-fought reforms:

- Write or talk to the local media and legislators about the need for reform and the inherent unfairness of the supreme court's making laws by judicial fiat.
- Discuss with patients the need for lawsuit reform and the court's lack of accountability to the voters who elected them.
- Support the Illinois State Medical Society Political Action Committee to help expand its focus on the Illinois judicial election contests in order to improve accountability and openness.

IDPR DISCIPLINES

This information, published as space permits, is reprinted from the Illinois Department of Professional Regulation's monthly disciplinary report. IDPR is solely responsible for its content.

August

Michael J. Reinstein, Skokie – physician and surgeon license reprimanded for allegedly improperly admitting a patient to a psychiatric hospital based on information given by a family member who was under psychiatric care at the time.

Bharati Shah, Glenview – physician and surgeon license reprimanded and fined \$2,000 for billing a patient as a new patient even though the patient was an established patient.

John Leo Showel, River Forest – physician and surgeon license reprimanded for improper treatment of a patient who had widespread metastatic breast cancer with chemotherapy.

Richard G. Smith, Naperville – physician and surgeon license reprimanded and fined \$500 for billing a patient for services not rendered.

Rafael J. Vargas-Zapata, Burbank – physician and surgeon and controlled substance licenses placed on probation for two years for prescribing Vicodin, a Schedule III controlled substance, to a patient when that use was not medically indicated.

Thomas E. Wood, Centralia – physician and surgeon license placed on indefinite probation for failure to properly document the prognosis of a patient and the need to perform surgical procedures.

September

Glenn Leroy Bynum, Chicago – physician and surgeon license reprimanded for failure to notify the Department of a medical malpractice settlement.

Michael Delaney, Carbondale – physician and surgeon license placed on probation for five years after being convicted of raising cannabis in his home.

Richard Famularo, Hingham, Mass. – physician and surgeon license issued on indefinite probation after being disciplined in the state of Massachusetts.

Vinod Goyal, Barrington – physician and surgeon license reprimanded and fined \$2,000 for making misleading statements at a hearing before the Illinois Health Facilities Planning Board regarding the physical condition of the facility in which he was practicing medicine.

Zakira Khan, Chicago – physician and surgeon license reprimanded and fined \$700 for failure to furnish medical records for seven months after numerous requests and a subpoena were issued.

Scott Ludwig, Bettendorf, Iowa – physician and surgeon license reprimanded and controlled substance license indefinitely suspended after a settlement was reached in a civil action alleging he failed to maintain complete and accurate records of controlled substances he received and dispensed, and after he entered into a disciplinary agreement with the Kansas State Board of Healing Arts as the conduct occurred when he practiced in that state.

Mohammed Ragab, Chicago – physician and surgeon license placed on probation for three years for maintaining an unsafe office environment and engaging in questionable insurance billing practices.

Malcolm Spencer, Danville – physician and surgeon license reprimanded for treating a patient with Methotrexate for a prolonged period of time without conducting a liver biopsy.

Morton Willcutts, Chamberlain, S.D. – physician and surgeon license restored to indefinite probation.

October

Eric Alfon, Toulon – physician and surgeon license placed on probation for two years for allegedly holding himself out as a dermatologist without proper credentials and exceeding the scope of his hospital staff privileges.

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PAGE 2

Illinois Medicine

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PAGE 5



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ISMS PRESIDENT JANE JACKMAN, MD (LEFT), discusses managed care health care quality as part of a panel assembled Jan. 21 in Chicago before Sen. Carol Moseley-Braun (D-Ill.). Other panelists were (from left) Terrold Butler, MD, and Ronald Hickombottom, MD, both of the Chicagoland Physician Association; and Anthony Cole, vice president, Haymarket Center, Chicago.

Michael Reese physicians make run for ownership

PENDING: Buyout effort may be 'David vs. Goliath.'
BY LINDA MAE CARLSTONE

[CHICAGO] The outcome is still pending in the saga of the physicians who have banded together to buy Columbia Michael Reese Hospital and Medical Center, the hospital that employs them. Yet just attempting this bold move is a test of the physicians' ability to regain control over health care decisions by becoming their own bosses.

"It's a David vs. Goliath story," said Claudia Fegan, MD, immediate past president of the Chicago hospital's medical staff and a member of the acquisition team. "The whole issue of employee-ownership – that physician-employees want to buy back the hospital from a for-profit behemoth like Columbia – is very attractive to a lot of people."

The notion of employees purchasing Michael Reese strikes a chord with many physicians, said Theodore Kanellakes, MD,

chairman of the ISMS Organized Medical Staff Section. "Physicians would love to try to do this. They see it as a chance to remove the adversarial relationship that has developed [at many hospitals] between administration and staff over the last seven or eight years. Although frustrated physicians often talk about 'buying them out,' when the subject of the hospital's price tag arises, it rarely goes any further."

Michael Reese physicians have learned that adding financial wheeling and dealing to their daily health care responsibilities is demanding. "This is no small venture, and it's not for the timid at heart," said Dennis Levinson, MD, another member of the Michael Reese acquisition team that is diligently working to pull together a coalition of investors. Meetings, huddles and negotiations eat up five to six

(Continued on page 10)

Judicial candidates pose clear choices for physicians

ELECTION: IMPAC redoubles its efforts in these races. BY JANE ZENTMYER

[CHICAGO] The Illinois Supreme Court's decision to strike down the 1995 tort reforms may have discouraged tort reform supporters, but they can do something about it in the March 17 primary election: cast an informed vote for a judicial candidate.

"The Illinois Supreme Court's tort reform ruling illustrates what happens when justices are out of touch with the public," said Jere Freidheim, MD, chairman of the Illinois State Medical Society Political Action Committee. "IMPAC plans to take a closer look at all judicial candidates and to inform physicians of their qualifications so they can vote accordingly."

In this election cycle, no positions are open on the seven-member Illinois Supreme Court, but three spots are open on the state's five appellate courts. While they may not attract much media attention, the appellate courts play an important role in the state's judicial system and are usually a stepping stone to the Supreme Court.



In the 1st District Appellate Court, which encompasses Cook County, candidates are vying for two open seats vacated by retired justices Edward Egan and Dom Rizzi. The primary election winners will face challenges in the fall general election.

Although 10 Democrats want Egan's seat, political analysts say two candidates – Kenneth Gillis and Marvin Leavitt – are the leading contenders for the party's nomination. The tort reform decisions of Gillis, currently a Cook County Circuit Court judge, will likely make him the favored candidate of the Illinois Trial Lawyers Association. Gillis ruled the entire tort



Leavitt



Gallagher

reform statute unconstitutional in 1996 for many of the same reasons the Illinois Supreme Court did. Gillis, for example, found that the \$500,000 cap on noneconomic damages has no rational basis. "There is no evidence that juries or judges, as triers of fact, cannot make reasonable and accurate determinations of these types of damages," he wrote in a 1996 decision. The cap, Gillis also wrote, "presents a more invidious and secret way of undermining the right to a jury trial than any heretofore designed."

Leavitt was appointed by the Supreme Court to fill Egan's spot in late 1996, but, according to the law, voters must choose a replacement in the election most closely following the appointment. During his time on the appellate court, Leavitt has written more than

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Rural health care landscape changes

GRADUAL: Budget act affects reimbursement, staffing, telemedicine issues. BY JANE ZENTMYER

[CHICAGO] As bits and pieces of the Balanced Budget Act of 1997 are slowly implemented, the country's health care system will change to accommodate the government's most recent effort at reform. The rural health care landscape is one part of the system that will have to adjust.

Over the next six years, for example, Illinois will eliminate

the current 100 percent cost-based reimbursement provided to Federally Qualified Health Centers and Rural Health Clinics to pay for services used by Medicaid patients in managed care plans, said Philippe Largent, director of legislative affairs for the Illinois Primary Health Care Association. The phaseout ensures that FQHCs

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Illinois' AIDS, HIV-related deaths fall for first time

[SPRINGFIELD] Illinois deaths from AIDS and HIV-related illnesses fell 21 percent in 1996, the first decrease since the epidemic began in 1981, the Illinois Department of Public Health announced. "Despite this encouraging news, we must prevent HIV infection from occurring in the first place to succeed in the fight against AIDS and HIV," said IDPH Director John Lumpkin, MD.

In 1996, 1,186 AIDS and HIV-related deaths were reported to IDPH compared with 1,494 such deaths reported in 1995. AIDS and HIV-related deaths among men fell 23.1 percent, from 1,309 in 1995 to 1,006 in 1996. Deaths among women fell 2.7 percent, from 185 in 1995 to 180 in 1996.

The state's AIDS and HIV numbers showed that deaths decreased the most among white males. "Clearly, we must reach out to all populations," Dr. Lumpkin said. "In particular, we must ensure that women and minority communities have effective prevention programs and quality medical care." Deaths among white males fell 32.6 percent compared with a 12.9 percent drop among African-

American males. While AIDS and HIV-related deaths among African-American females rose about 1 percent, the figures for white females dropped 8.3 percent.

Dr. Lumpkin attributed the decreases to the drug combinations being prescribed for many HIV patients but cautioned that the treatment isn't a cure. "The best treatment remains the prevention of new infections."

The drug combination is available to Illinois residents who qualify for assistance through the Illinois AIDS Drugs Assistance Program. The program experienced financial troubles last year because of the costs of the expensive drugs, but a supplemental appropriation allowed ADAP to expand its formulary so that all protease inhibitors and anti-retrovirals approved for use by the U.S. Food and Drug Administration could be offered to HIV and AIDS patients.

For fiscal year 1998, ADAP has an estimated \$16 million budget, about three times what it spent in fiscal 1996.

Last year, the ISMS Board of Trustees agreed to support an increase in the state's ADAP funding. ■

KENNETH PRINTEN, MD, who serves as chairman of the Chicago Medical Society's 1998 Midwest Clinical Conference Feb. 20-22 at Navy Pier in Chicago, talks with patient Pat DeCarlo of Buffalo Grove. For more information about the conference, call (312) 670-2550, ext. 341.



Andrew Corrigan Halberstam

Rural health care

(Continued from page 1)

and RHCs receive their reimbursements directly from Medicaid rather than a patient's managed care plan.

"It's a mixed bag. We got what we wanted — clarification from the feds so that the state knows what it has to do," said Largent, in reference to reimbursement coming directly from Medicaid, "but we also lost because the act phased out the prize in the sky." But, he added, "six years is a long time, and who's to say that another Congress won't see the good of cost-based reimbursement and why it's necessary."

The reimbursement phaseout levels the playing field among FQHCs, RHCs and solo or group physicians, addressing a concern that ISMS brought to the American Medical Association, said William Tortoriello, MD, chairman of the ISMS Committee on Health Care Access. "One of the problems we have [in attracting physicians into rural practice] is that when physicians go to rural areas, their reimbursements are less, but their costs remain high," he said.

Rural health clinics may also find it harder to get and keep their certification. Facilities seeking RHC status can no longer waive the requirement that they employ a midlevel practitioner such as a physician assistant, said Mary Ring, chief of the Illinois Department of Public Health's Center for Rural Health. Only

those facilities that already have their RHC certification can get extra time to fill a midlevel practitioner position.

The act also created the Medicare Rural Hospital Flexibility Program to provide cost-based reimbursement to rural hospitals that become critical access hospitals. To participate, states must develop a rural health plan that identifies critical access hospitals, provides for the creation of rural health networks, promotes regionalization of rural health services and improves rural residents' access to hospital and health services.

State officials are now working on Illinois' rural health plan and expect to submit it for U.S. Health Care Financing Administration approval early this year, said Ring, who is also the president of the Illinois Rural Health Association. The plan, she said, will focus on identifying the state's critical access hospitals. The budget act's criteria for critical access hospitals include the stipulation that the hospitals must be existing non-profit or public hospitals and must make 24-hour emergency services available according to state guidelines.

Hospitals that receive the critical access designation "don't have to meet the hospital standards for staffing requirements," said Barbara Dallas, senior director of rural health services for the Illinois Hospital and HealthSystems Association. For example, standards now require hospitals to employ a full-time lab technician and medical technologist.

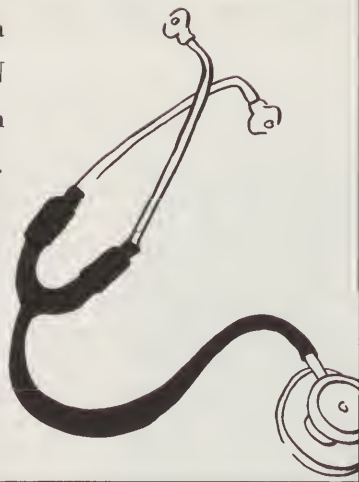
The balanced budget act also allows Medicare Part B to pay for professional consultations via telecommunications systems by January 1999, according to IHHA. This reimbursement is available only for Medicare patients in designated health-professional shortage areas, according to the National Rural Health Association. Cost of these services cannot exceed Medicare's rates and cannot include telephone line charges or facility fees. Payment is subject to coinsurance and deductibles, and the fee must be split between the referring and consulting physicians. ■

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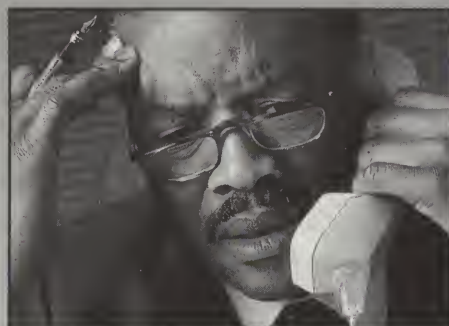
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Democratic governor hopefuls discuss health care issues

PRIMARY: Candidates talk about managed care reform.

BY LINDA MAE CARLSTONE

[SPRINGFIELD] With Gov. Jim Edgar out of the running, a feisty four-way battle has ensued in the Democratic primary to win the chance to wrest the state's top political spot away from the Republicans.

The lineup of candidates seeking the Democratic nod reads like a "Who's

Who" of Illinois politics: U.S. Rep. Glenn Poshard; Jim Burns, former U.S. attorney for northern Illinois; Roland Burris, former Illinois attorney general; and John Schmidt, former associate attorney general of the United States, a position that made him third in command of the Clinton Justice Department. The winner is likely to face-off against Illinois Secretary of State George Ryan, who will have only a minor challenge in the Republican primary.

Several health care issues have come to the forefront in the campaign. Last November, Schmidt announced that, if elected, he would initiate a health maintenance organization consumer's bill of rights for Illinois like those passed in 25 other states. "HMO participants need to know what they're getting and need to get the quality service they are paying for," he said.

Schmidt said his administration would publish an annual HMO report card on plans in this state, providing consumers with data such as benefits and preventive care offered by the plans, the number of participating physicians and customer satisfaction rankings. In addition, Schmidt said that as governor he would outlaw gag rules and implement appeals mechanisms to use when coverage is denied.

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Noting that similar measures have failed to pass the Illinois General Assembly, Schmidt said the majority of provisions in his bill of rights could be implemented by executive powers already available to the Illinois Department of Insurance.

Poshard agreed that providers' responsibilities, including due process, should be spelled out clearly in a patients' bill of rights. "We don't want to see situations where insurance or managed care overseers dictate medical practice," he said. Objective reviewers outside the insurance company should handle decisions on health care apportionment, he said.

Anecdotes abound about managed care plans making decisions based on the bottom line, said Burns, who said these abuses ought to stop. "We need to make every effort to ensure that doctor-patient relations are left intact." But, he added, he does not want to impose new levels of bureaucracy to settle these problems if that can be avoided.

Burris said he is still hammering out the details of his health care package, but he will examine "managed care problems created when insurance companies try to practice medicine."

In Congress, Poshard has made rural

health care a top priority, and he promises as governor to continue the crusade. Recently, the National Rural Health Association named Poshard as rural health legislator of the year. Poshard is the Democratic leader of the Rural Health Care Coalition, which he said

successfully pushed for money to be included in the federal 1997 budget bill to advance telemedicine.

"Telemedicine is a great way to upgrade quality of care in underserved areas," said Poshard, a five-term congressman from Marion. It can also be used to provide rural physicians with expanded training opportunities.

Burris vowed to use the governor's office to promote preventive medicine as a means of diagnosing diseases in the early stages. "I would encourage people through public information to get checkups," he said. "We don't want to end up with the costs being placed on

the taxpayers when they need to be treated for catastrophic illnesses."

The Democratic candidates said they were still studying their positions on the scope of practice for advanced practice nurses, an issue likely to be hotly debated in the spring General Assembly.

On tort reform, each candidate except Poshard is opposed to caps on noneconomic damages. But even Poshard, who voted in Congress for caps on noneconomic losses, offered little hope that the caps could be revived in Illinois now that the Illinois Supreme Court ruled them unconstitutional. "I don't see how that could be reversed." ■



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REPORT for Illinois Physicians

MEDICARE COVERAGE OF PET SCANS EXPANDS

Claims Processing on Hold

Coverage Expands

Effective January 1, 1998, Medicare expanded coverage of positron emission tomography (PET) scans to include FDG PET scans for the characterization of single pulmonary nodules and the initial staging of lung cancer. PET scans will be covered when performed with a camera that has either been approved or cleared for marketing by the Federal Drug Administration to image radionuclides in the body. Dedicated PET scanners and coincident imaging gamma cameras are the devices that currently meet this criterion.

In order to assess the impact on clinical care, a system of coding similar to that used for Rubidium-82 PET scans will be adopted. Rather than using a single CPT code for all scans, HCFA will establish codes that represent not only the type of scan but also the result of the PET scan and any preceding CT scan. In some instances other clinical findings will be included in the code. This coding system will facilitate the ongoing evaluation of how clinicians utilize this technology in clinical practice. The coverage policy also explicitly recognizes that the use of PET scans represents but one clinical option in the diagnosis and staging of lung cancer. The role of the PET scan should be thoroughly understood by the patient and physician before ordering the test. In the case of single pulmonary nodules, the use of a PET scan can avoid the need for a biopsy in the event that the PET scan is negative. The use of a biopsy following a negative PET scan is inappropriate in the typical case. For this reason carriers will deny payment for biopsy of a single pulmonary nodule that is PET negative unless the claim is supported by documentation explaining the medical necessity for the biopsy.

Claims on Hold

Although this coverage is effective January 1, 1998, Medicare contractors are unable to process claims until coding and claims processing instructions are issued. HCFA is developing HCPCS codes that will report the result of the scan and also any prior CT study. Providers should hold claims until specific claim submission procedures are issued. At that time claims can be submitted and will be paid for services performed after January 1, 1998.

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EDITORIAL

Advanced practice nurses

There is no doubt that advanced practice nurses serve a worthwhile role in patient care by enhancing the quality of care while working in collaboration with a physician. ISMS embraces the role of advanced practice nurses on the health care team and believes they should have appropriate licensure and recognition under Illinois law. However, ISMS also strongly advocates an advanced practice licensing law that recognizes major differences in training, experience and skill between advanced practice nurses and physicians.

At no point should advanced practice nurses be considered substitutes for physicians. That's why ISMS believes patients are best served when advanced practice nurses work within the boundaries of a written collaborative agreement with a physician who provides services in the same general area as the advanced practice nurses.

The Society isn't the only group studying the issue of advanced practice nurses' scope of practice and licensure: The nursing lobby has been active in the past year in its effort to solicit support for its cause, often spreading misleading information about the issue. At the same time, the ISMS Council on Education and Health Workforce has worked diligently with representatives of nurses' organizations in an effort to reach a possible compromise on statutory recognition for advanced practice nurses. In addition, an ad hoc committee of physi-

cian specialty societies has met with nursing representatives to talk about concerns from both professions.

When legislation on advanced practice nursing is introduced during the General Assembly, be prepared for some heated debate – and an immediate call to action. Physicians can take several steps to help lead to legislation recognizing the needs of their profession. First and foremost, they can become familiar with the ISMS position through the Society's white paper on the issue. They can contact their legislators about the need for specific, written collaborative agreements between physicians and advanced practice nurses, appropriate ratios to limit the number of collaborations a physician can have and careful licensure of these individuals.

The white paper is available free of charge by calling or writing to ISMS, or by downloading it from the Society's site on the World Wide Web, www.isms.org. A quick read, the document spells out the reasons behind the ISMS position, providing valuable background for letters to the media and lawmakers, as well as for appearances before civic and professional organizations. Extra copies of the ISMS position paper are also available for distribution to patients. Your phone calls and letters to legislators and public appearances soliciting grass-roots support for the measure can make a huge difference. Voice your opinion now so that lawmakers can take your views into account!

PRESIDENT'S LETTER

The doctor-patient relationship – an endangered species?

Jane L. Jackman, MD



Patients want a good one-on-one relationship with a doctor empowered to do what is right for them.

Ideally, the practice of medicine should focus on the totality of the patient as an individual. It should represent a unity of several disciplines focused on healing disease and the ultimate good of the patient. However, in recent years, several forces have caused the doctor-patient relationship to weaken and crumble at its edges.

One of the most significant forces is the new way health care is financed and delivered. Managed care has helped rein in medical costs recently. However, the cost-cutting has often come at the expense of long-standing doctor-patient relationships. Understandably, patients are upset when they are forced to switch to a new doctor whose only attraction is being listed on their HMO's panel. They want the right to choose their own physician. Many of my former patients are forced to change doctors every time their employer changes insurance plans. After a while, some of these patients don't want to invest the time and emotional energy required to forge a new doctor-patient relationship, especially when it will probably be a short-term affair. As one of my long-standing patients pointed out to me, "When you're sick, it's nice to have a doctor who doesn't have to waste time asking about your past medical problems."

Some patients today question the motivation of their doctors. The media, which spotlighted gag clauses more than a year ago, has helped focus attention on the immorality of some managed care contracting practices. In doing so, the media also planted the seeds of mistrust of their doctors in our patients' minds. Despite the managed care industry's assertion that gag clauses are simply a case of collective hallucination by the medical profession, we have seen examples of them in Illinois contracts. The American Medical Association recently reviewed Aetna U.S. Healthcare contracts from several states and also found gag clauses. These provisions create major ethical and legal problems for any doctors who sign them and they destroy doctors' relationships with patients.

Our patients are beginning to understand the interference in medical decision-making when insurance clerks deny medical services, whether it is a specialty referral, a diagnostic test or surgery. Patients support our clinical autonomy and I believe they also want a good one-on-one relationship with a doctor empowered to do what is right for them.

Patients have minimal allegiance to their insurance companies. I believe they can become our allies in our fight for our autonomy that we need to remain their advocates. As Rep. Greg Ganske (R-Iowa) observed: "The majority of the American people is calling for regulation of managed care because of the abuses they perceive."

In Washington, President Bill Clinton has asked for passage of the Consumer Bill of Rights and Responsibilities. This is a good first step toward developing a comprehensive approach of ensuring patients rights under managed care.

In Illinois, we are continuing the slow work of passing the Managed Care Patient Rights Act. We need the force of law in our state to make sure that managed care patients have the right to choose their doctors and the right to work with their doctors when making treatment decisions. Patients also need understandable information about their health plans and the reassurance that their doctors will always be their advocates.

Since the passage of H.B. 626 last year, the debate has shifted to the Senate. Quite honestly, it won't be as easy to pass a comprehensive patient rights bill in the Senate as in the House. However, it is very doable if we all work hard and speak in unity. If every member were to contact their senators about MCPRA and urge its passage this spring, we would be a powerful voice for our patients. Let's remember that the doctor-patient relationship is the "gold standard" of medicine. If this relationship continues to be undermined, the quality of care suffers. We must be political activists and speak up for our patients' rights!

GUEST EDITORIAL

Organization helps families understand fertility options

By Bert Scoccia, MD

The recent birth of the septuplets in Iowa emphasizes the fact that for many couples struggling with infertility, enhanced fertility can bring happiness. Even though this case also points to the risks and ethical issues involved with high-order multiple pregnancies, some couples who want desperately to conceive a child may have watched the news reports of the births with longing, sadness and frustration.

Infertility can take its toll: Couples may become mired in anxiety and stress while they struggle to conceive. They become angry at themselves, concerned about the ticking of the woman's biological clock and distressed over the amount of time lost without pregnancy. For the last 10 years, I have worked with Resolve of Illinois Inc., a volunteer organization that helps couples deal with infertility and informs them about options that may not have been considered. I often refer couples to the group for support, and patients have been referred to me through the organization's network.

Resolve has been a tremendous

resource for physicians. Doctors are invited to quarterly meetings in Chicago for updates about what Resolve offers infertile couples as well as short talks on issues like patients' emotional problems and the choice to stop treatment. Often, Resolve learns from physicians about new options to treat infertility and shares that information with couples.

More Ob/Gyns and family physicians are treating infertility, partly because of the demand. Fertility specialists like myself, Ob/Gyns and some family physicians are seeing more women who are trying to conceive later in life, after their careers and other aspects of their lives have been established.

With more couples seeking treatment, Resolve offers worthy resources for information about alternative therapies. It presents newsletters; seminars featuring physicians, social workers and women who have experienced infertility and one or more of the treatments; and support groups for women, men and couples. Often, patients get locked into certain ideas about treatments and may not

know enough about advances. It helps for couples to hear from other patients who have undergone treatment so that they can understand what is involved.

Every woman experiencing infertility is reminded monthly that conception is not occurring, and this is very distressing. Resolve can put these women in contact with others in similar situations to provide reassurance and share coping mechanisms. Men become stressed, too, and 50 percent of infertility problems are male-related. Today's medicine can help all but a very few men suffering from infertility, and Resolve has been at the forefront in spreading this information.

Because the demand for treatment is so high, more patients are now bringing up infertility with their family physicians or Ob/Gyns and seeking basic evalua-

tions and treatments. If they don't conceive within three to six months of treatment, the couples are referred to reproductive specialists who may speed up the conception and treat the complications. By providing patients with information about treatment options and a support network to complement our medical care, Resolve can often ease burdens for future parents.

For more information about Resolve of Illinois Inc., call (800) 395-5522.



Dr. Scoccia is a member of Resolve of Illinois Inc. and director of the division of reproductive endocrinology and fertility at the University of Illinois-Chicago.



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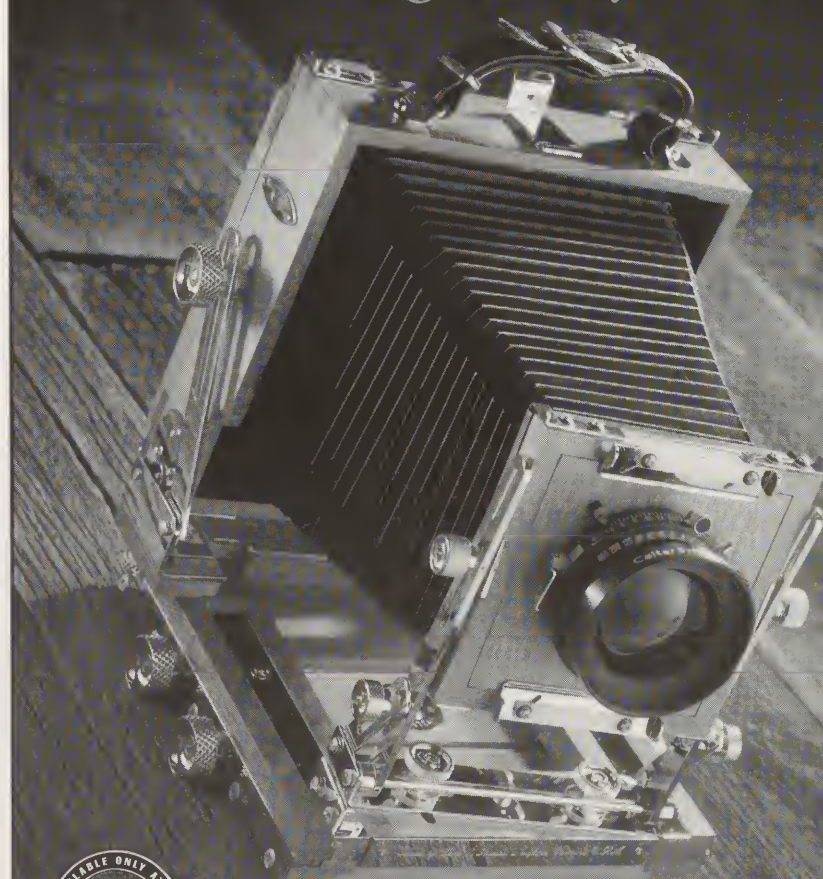
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ISMIE Update

Getting insurers to open doors for the care patients need

Physicians can make the case for medically necessary tests.

BY MINDY KOLOF

In the world of managed care, prescribing basic tests like a mammogram or a lipid profile can be anything but simple. Insurance may not cover the tests, leaving the patient to pay – and sometimes unwilling to comply with your treatment plan. How can physicians handle this in a way that's medically appropriate, legally correct and ethically responsible? By always recommending what's best for, and advocating on behalf of, the patient.

"The physician's primary duty is to the patient," said attorney Kevin Glenn of Bresler, Harvick & Glenn, a Chicago law firm that specializes in defending physicians involved in malpractice cases. "They owe a reasonable standard of care to the patient, independent of anything else. The relationship

between physician and patient never changes."

Steve Wilk, MD, a Bolingbrook family physician and president-elect of the Illinois Academy of Family Physicians, has adopted that philosophy. "I don't know one insurance plan requirement from the other and I don't care to – it's just the patient and me. I don't want that relationship to be clouded by the type of insurance they're carrying." Members of his staff, however, are familiar with the various insurance plans and notify him when there's a coverage problem.

Two options exist for physicians whose patients need a test not covered by insurance, Glenn said: "They can tell patients they must pay for the test themselves. Or the physician can call the insurance

provider and convince them that it's in their best interest and that of the patient to cover this medical event."

The latter is the right option, according to Henry Martin-del-Campo, MD, a family physician and medical director at Methodist Medical Center in Peoria. "It's the doctor's responsibility to explain the importance of the test to the insurance company; the last resort is for the patient to pay. More than any other time in our careers, it's important for doctors to go to bat for their patients."

Dr. Wilk, as well, has taken on a supportive role for his patients. His staff will obtain insurance company criteria for a given test. "If the test doesn't meet them, I might then speak to the provider's medical director," he said. "Often conversa-



Robert Neubecker/SIS

tions at that level lead to a compromise."

Glenn recommended that physicians develop a "sales technique" when dealing with insurance companies. "Remember, a little bit of honey goes a lot further than confrontation. Once a doctor gets a reputation as a reasonable guy, most of his requests will be granted."

J. Kelly Carroll Jr., MD, a family physician in Silvis, deals with Medicare coverage denials every day. He prepares patients for the denial by careful explanation. Medicare provides for tests such as mammograms only every two years, for example, although medical guidelines recommend yearly mammograms. "This doesn't mean the test is not medically necessary," he tells patients, "but because of limited resources, Medicare is not going to provide coverage."

Dr. Carroll's Medicare waiver form for patients, in which they agree to be personally responsible for payment, includes this wording: "If Medicare determines that a particular service is not reasonable and necessary, Medicare will deny payment for that service. As your physician, I feel that the service is in your medical interest. I believe that, in your

case, Medicare is likely to deny payment." The process, he said, has not changed what he prescribes, only what he tells patients.

Said Dr. Wilk, "We've been comfortable with writing an order and it's done. Now we have to look at what is clearly medically indicated and whether there's evidence to back it up."

Candor while prescribing tests can help physicians avoid lawsuits. Physicians also should note in a patient's chart that a test was suggested, advised attorney Jim Christman of Wildman, Harrold, Allen & Dixon in Chicago. If a mammogram was recommended but the insurance company wouldn't cover it and the patient then opted not to have the test, "you can refer back to your notes and be pretty well covered [if cancer is later discovered]. You're not going to be hurt by taking the time to document in detail what you told the patient – the more detail, the better off you'll be."

In Dr. Wilk's opinion, honesty in dealing with patients and their insurance providers is the only way to handle issues. "If you can demonstrate that it's the right care and medically necessary, I've yet to see an insurance company that won't cover it."

MALPRACTICE ROUNDUP

Surgeon justified in not reattaching man's hand

A Virginia jury rejected a malpractice claim against a plastic surgeon who followed a construction worker's wishes that his severed hand not be reattached, according to the Nov. 10 edition of the National Law Journal.

In *Passmore vs. Grenga*, the patient claimed he saw the sign of the devil on his hand and sliced it off at the wrist. The man and his severed hand, which was packed in ice, were rushed to the hospital, where he consented to reattachment of the hand but later denied con-

sent. Uncertain about how to proceed, the surgeon sought opinions, and a judge told him that if he performed the surgery against the patient's will, he could be charged with criminal assault and battery. As a result, the physician decided not to operate.

The patient later sued the physician for malpractice, charging that the doctor should have known he was incapable of giving or denying consent. The man's suit against the psychiatric residents at the hospital was settled before trial.

Physician, hospital pay after man falls following surgery

The widow of a patient who bled to death after a fall following femoral bypass surgery won a \$100,000 settlement, according to the October edition of *Medical Malpractice Law & Strategy*.

In *Hinkson vs. Ilkhanizadah*, the patient got out of bed two days after surgery and fell, dislodging the graft where the tubing met the artery. The patient bled to death one-and-a-half hours later.

The plaintiff attorneys told a New York

superior court that the graft had been placed improperly, causing the tubing to discharge. They also claimed that the hospital was negligent for failing to accompany the patient when he got out of bed. The attorneys for the physician and for the hospital said the graft was placed properly and the fall was an unforeseeable risk.

The fact that the patient had terminal bone cancer with a life expectancy of about two years mitigated the amount of the settlement.

AMA blasts Aetna contracts

Illinois physicians are concerned about provisions that go beyond gag clauses.

BY LINDA MAE CARLSTONE

For more than two years, gag rules have monopolized the spotlight on managed care contract abuses, yet plenty more danger zones lurk in physician agreements nationwide, including in Illinois. The American Medical Association recently unleashed several new weapons in the battle to wipe out managed-care-agreement language that is unfair to physicians and patients. In December, the association publicly criticized Aetna U.S. Healthcare, alleging that its contracts in Florida were written to let the company unilaterally change patient-care procedures and policies.

The AMA is not saying problems are limited to Florida, nor is it "singling out Aetna," said AMA Trustee William Mahood, MD. The Aetna contracts present just one example of a widespread trend by many companies, he said. "We've seen some pretty nasty language in other contracts and have sent letters to other plans." One particularly egregious provision declared that any physician who attempted to negotiate the contract terms would automatically be dropped from the plan, he said.

Aetna's Florida contracts came to the AMA's attention through the association's newly formed Division of Representation, charged with the task of hunting down managed care contracting practices that may compromise patient care.

In an 11-page letter to Aetna, the AMA detailed point-by-point a list of what it called serious questions about both the fairness and enforceability of the company's Florida contracts.

Five other states besides Florida also have logged complaints about Aetna contracts with the DOR, according to Dr. Mahood. The reason the Florida contract received special attention is that "attempts to get in a dialogue with Aetna were ignored," he said. "When they declined to talk to us, we released the let-



One particularly egregious provision declared that any physician who attempted to negotiate the contract terms would automatically be dropped from the plan.

ter to the public."

Aetna U.S. Healthcare denied the AMA accusations, stating there are no gag clauses in its contracts. "Form contracts are not contracts of adhesion. No one is forced to sign, and negotiation of specific terms is routine. Aetna U.S. Healthcare has spent many years refining its provider contract forms, with the goal of having a flexible document that protects the interest of our members and complies with applicable regulations," the 14-million-member managed care company said in a prepared statement.

At its interim House of Delegates meeting in Dallas in December, the AMA unveiled model contract language that balances the rights and obligations of managed care companies and physicians. "The purpose is to protect patients so

they don't have to be nervous or fearful when they go to the doctor," Dr. Mahood said. To obtain a model contract, physicians may call Lynne Gavin at the AMA, (312) 464-5490.

Illinois is not immune to the contract concerns identified by the AMA, said several attorneys who negotiate contracts here. In fact, contracts offered to physicians in this state are laden with one-sided provisions favorable to managed care companies, they said.

Some language makes gag rules seem like small potatoes, said Judee Gallagher, a Chicago attorney. Much more serious, Gallagher said, are contracts that hold physicians liable for deficits in the hospital fund, which the attorney has seen creeping into the Illinois market in the past year. Another contract issue unsettling for physicians allows managed care enrollees to receive special services outside the participating physicians' services. "That's financially unacceptable if a physician group is paid on a capitated basis, because specialists are under contract with the physician group on a fee-for-service," she said.

(Continued on page 8)

ISMS helps members find legal services

When patients need a physician, they often bypass the Yellow Pages and turn to friends and relatives for a reliable reference. The same rule applies to physicians in need of legal advice, and one place to which they can turn is the ISMS Lawyer Referral Network. The member service provides referrals from a panel of more than 30 attorneys whom the ISMS legal staff has screened.

To receive a referral, members should call the Society's legal staff at

(217) 528-5609 or (800) 545-7876 and explain their needs. A staff member will then provide the names of two or three lawyers, in the members' geographic area if possible, whose experience matches their needs.

All attorneys in the network have completed questionnaires describing their experience, training and areas of specialization, said ISMS General Counsel Saul Morse.

"We guarantee that these attorneys have experience representing

physicians in the health care area."

The service began about three years ago in response to a growing need for legal assistance on managed care contracting issues. Most of the referrals are related to managed care, incorporating practice and employment contracts, Morse said. However, the service is available to members seeking an attorney for any purpose, he said, and it has been used for a variety of reasons, including divorce, real estate and, in one instance, traffic violations.

Progress made in banning gag clauses

As efforts to wipe out managed care contract provisions that interfere with physician-patient relations continue, 36 states have climbed aboard the anti-gag-clause bandwagon and passed varying forms of legislative and regulatory actions to prohibit carriers from restricting what a provider can say to a patient.

Last spring, for example, the Arizona Legislature amended its consumer protection measure to prohibit restrictions on good-faith communication between providers and patients about a patient's health care, medical needs, treatment options and health care risks or benefits. A new Florida law requires contract language that states a health care provider will not be restricted from communicating with his or her patient when the physician feels the information is in the best interest of the patient's

health. Several gag-clause proposals are pending in Illinois, but the Legislature has approved none of the bills.

Despite the headway in this area, "gag clauses are still out there," said AMA Trustee D. Ted Lewers, MD. "I think we have to be very careful when we say that they do not exist because our patients suffer from this." In fact, the AMA in December complained that Aetna U.S. Healthcare's physician contract contains a gag clause that may violate Florida state law.

A report released in September by the U.S. General Accounting Office probably has contributed to some perceptions that gag rules have vanished. The report concluded that explicit gag clauses were not found in a review of HMO contracts. But the GAO analysis is woefully incomplete, according to an ISMS analyst. First, the agency reviewed only con-

tracts submitted voluntarily, so contracts containing gag clauses in all likelihood would have been withheld, the analyst said. Further, said the analyst, the GAO recognized that HMOs can use other forms of written or oral communication such as guidelines, protocols, physician profiling and approval procedures to modify physician behavior.

ISMS will introduce into the Illinois Legislature this spring a Managed Care Patient Rights Act that prohibits gag clauses, said ISMS President Jane Jackman, MD. But beyond gag clauses, the act also bans practices that prevent physicians from advocating for their patients, such as termination without due process.

"Doctors must be comfortable in knowing that they will not be deselected for being strong advocates for their patients," she said. "They shouldn't be penalized for doing what is ethically right for their patients."

In addition to pushing its own legis-

lation, the Society will advocate for its managed care provisions to be included in a bill now being prepared for the Illinois Senate, Dr. Jackman said. "The state would be better served by allowing physicians to do their job properly," she said. Fierce opposition by managed care companies and others helped block managed care provisions previously introduced in the General Assembly. Dr. Jackman urged physicians to contact their senators immediately and talk with them about the importance of stopping gag practices and of having due process be a part of managed care contracts.

The AMA is also fighting to protect physicians from noncontractual methods used to control physician communication with patients, such as dismissal without cause, Dr. Lewers said. The AMA wants an appeals system included in every plan, he said. "If you're going to kick a physician out, that physician deserves a hearing."

AMA blasts

(Continued from page 7)

Norman Jeddeloh, a partner in the Chicago law firm of Burditt & Radzius, said he has seen plenty of abuses. "Many contracts are so convoluted they can be subject to post hoc interpretation," he said. Jeddeloh recalled one "incredibly difficult contract with a prominent

HMO that had so many different appendices applying to so many conditions that it was very hard to make any sense of it. To transform the contract into a good, clear, understandable piece would burn \$5,000 to \$10,000 of my client's money. And you can't go to an HMO and say you want to completely redo their contract."

Instead, he picks his battles. "Look at

what could be the basis for litigation," Jeddeloh advised. A top concern should be the indemnification issue, that is, when HMOs pass liability back to the physician when they get sued, he said. "That's an issue where I would fight for the best language possible, because that could kill a physician organization." Determining how physicians are paid through the pool and setting termination rights are also

worth the fight, Jeddeloh said.

Gallagher said physicians should compare contracts and sign with companies that are physician-friendly, "not just in financial compensation, but also in terms of having an efficient organization that responds quickly to credentialing and payment issues, that understands [the National Committee for Quality Assurance] and that offers efficient claims processing. Sometimes doctors are seduced into entering contracts with national companies they think will be big players in their market." She advises clients to consider the impact that newcomers will have on the market because it's not wise to sign a contract with onerous terms and let the company get a foothold in the area. "Then they can offer take-it-or-leave-it contracts."

Physicians could face disciplinary actions if they give contract limitations precedence over their patients, said Edward Bruno, an attorney with the Chicago firm of Bruno & Weiner who represents physicians in disciplinary matters. "Too often, contract terms don't mesh with a physician's responsibility to the patient," Bruno said. Jeddeloh agreed: "I tell physicians they have a responsibility to the patient. A physician in Illinois can't say to the medical disciplinary board, 'I didn't do the required test or I didn't keep the patient in the hospital long enough or prescribe the right treatment because the managed care contract didn't allow it.' The medical disciplinary board is not going to accept a managed care restraint or a group practice restraint as an excuse. The physician is almost forced to provide free care."

The AMA will continue to press for contract changes, Dr. Mahood said. Every delegate and alternate delegate left the interim meeting armed with the model contract language and instructions to widely distribute it in his or her state, he said. "We want it in the hands of state legislators, state insurance commissioners and managed care plans throughout the country," said Dr. Mahood. "We hope to see better contract language as plans continue to redo their contracts. We hope Aetna, as one of the largest plans in the country, will step up to the plate and make necessary revisions that set the pace for other plans."

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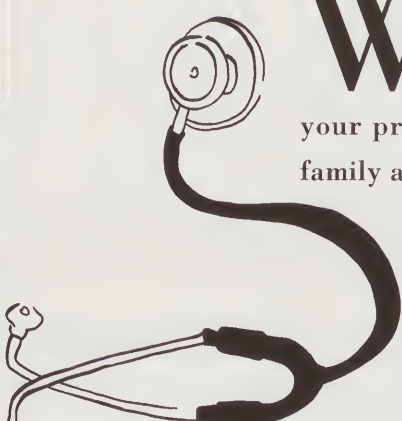
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Michael Reese

(Continued from page 1)

hours a day, he estimated. "Discussions run late into the night and we e-mail and fax each other constantly. Families are upset [with the time it takes]."

Some analysts are skeptical the physicians will be able to pull off the purchase. "It would be very difficult for a group of physicians to raise a significant amount of capital," said Pam Waymack, managing director of Phoenix Services, an Evanston-based managed care consulting firm. They will have to convince private investors that they can manage the hospital better than the small companies out there that manage distressed hospitals, she said. That's not impossible, Waymack said, particularly if the physicians can demonstrate they have an inside track on building market share and controlling costs.

James Unland, president of Health Capital Group of Chicago Inc., a Chicago consulting firm specializing in provider networks, said he sees several hurdles for any new Michael Reese ownership. For example, the hospital's patient mix during the last 20 years has been skewed heavily to Medicare and Medicaid. The institution is weak in primary care networks and heavy in specialty care, the physical infrastructure needs upgrading, and the hospital faces significant competition.

If Michael Reese is to succeed, the hospital's new owners must make more primary care inroads into the community and should try to develop one or two centers of excellence to distinguish it

from other hospitals, Unland said. Analysts like Unland caution physicians contemplating a hospital purchase against trying to run the whole show. "They will need trained businesspeople."

"Running a good hospital is a critical balance between good stewardship, conservation of resources and high-quality patient care," said Michael Reese President F. Scott Winslow. "Once you have a stake in something, you become more tuned in than you were the day before."

Buyout organizers say they are well-aware of the challenges. Physicians will not run the day-to-day operations, Dr. Fegan said. "We want doctors involved in decision-making, but we recognize the need for professional hospital management involved in administration."

Neither do they seek complete financial control, Dr. Fegan said. "We are going for a large investment pool." She described their vision for a broad-based coalition of physicians, community groups, employees and others as owners.

Dr. Fegan said the physicians, if successful in the hospital buyout, would begin their ownership by having "nurses, physicians, employees – the people who sweep the floor and admit people – sit together and talk about how we are going to take care of our patients, as opposed to having someone sit in an office at the top and dictate that down."

The physicians acknowledge they are up against negative publicity that has tarnished the hospital's once-sparkling image. Recent media coverage has spotlighted a lengthy Medicare investigation

of Reese's owner, Columbia/HCA Healthcare Corp., as well as the hospital's financial struggles.

Thomas Carlson, MD, current president of the medical staff, said the hospital has taken a bad rap. "You can say all the bad things you want about Columbia, but Michael Reese is salvageable because it's lean, mean and making a profit." Dr. Carlson has been at the hospital since he was an intern in 1976, "when it was the premier place to do an

internship this side of the Mississippi River. It's very sad to see everyone abandoning the principles we stood for. Yes, there have been cutbacks. But other hospitals are cutting back as well."

Organizers said they have met with several potential investors, but they declined to say if they have secured any commitments.

Dr. Levinson predicted his group will have something to announce within three months. ■

Judicial

(Continued from page 1)

150 orders and published 20 majority opinions, three dissenting opinions and one specially concurring opinion.

Before his appointment, Leavitt spent one year as a judge for the Circuit Court of Cook County and 17 years as a partner in Leavitt & Schneider, a Chicago firm he co-founded. Leavitt, a 1976 graduate of the Chicago Kent College of Law, specialized in criminal defense and has defended about 3,500 cases. A May 1995 Chicago Bar Association judicial evaluation said he's "an experienced practitioner who is well-respected for his integrity, temperament and demeanor."

Five candidates are seeking the other open 1st District Appellate Court seat. One of those candidates, Michael Gallagher, is a former ISMIE defense attorney. Gallagher, a 1978 graduate of Chicago Kent College of Law, was appointed to the appellate court in 1996 to fill the spot of the retiring Justice Rizzi.

Before his appointment to the appellate court, Gallagher spent six years as a Cook County Circuit Court judge. He also was a partner at Cassidy, Schade & Gloor where he concentrated in appellate and trial practice related to medical malpractice, products liability and general negligence. The Chicago Bar Association recently rated him highly qualified for the appellate court position.

The third open seat is in the 4th District Appellate Court, which covers 30 counties in central Illinois. Two Republi-

cans, Thomas Appleton and John Davis, are running for the party's nomination, and the winner will face Democrat Sue Myerscough in the November general election.

Appleton, a graduate of Chicago Kent College of Law, has been a Sangamon County Circuit Court judge since 1992. Before he joined the bench, Appleton spent 12 years in private practice and six years as a clerk and research director for the 4th District Appellate Court.

The state's appellate courts, which must accept every case appealed to them, determine the vast majority of state law, ISMS General Counsel Saul

Morse explained. "The decision of the appellate court is binding on every trial judge in the appellate court district," Morse said.

"If it is a decision on which none of the other four appellate court districts have ruled, then that decision is binding on the trial judges in those

other appellate districts until the appellate court judges from those districts have ruled." The appellate court's decision can be taken to the Supreme Court, but the high court accepts less than 10 percent of the cases appealed to it.

Appellate court judges also serve on Supreme Court and Illinois Judicial Conference committees. Although the Supreme Court is responsible for filling judicial vacancies, appellate court justices may make recommendations that can influence the court's appointment. Appellate court judges serve 10-year terms. When their term ends, judges must seek retention, which means they must receive 60 percent of the vote to serve another 10-year term. ■

*One of those
candidates, Michael
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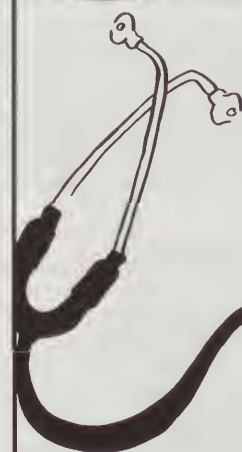
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candidates map
their positions

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Illinois Medicine

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your support

PAGE 5

New Part B carriers have been around the Medicare block

CHANGES: Planners strive for a smooth transition. BY LINDA MAE CARLSTONE

[CHICAGO] The Illinois Medicare Part B baton will soon pass to a new carrier, and planners say they are striving for a transfer with few negative effects on physicians and patients.

The weighty job of processing Illinois and Michigan Medicare claims for physicians and for supplier services will be handled by Wisconsin Physicians Service, in partnership with subcontractor National Heritage Insurance Co., the U.S. Health Care Financing Administration announced Jan. 30. Pairing two companies was necessary to handle the immense

workload, said Dorothy Burk Collins, regional administrator for HCFA, which runs the Medicare program.

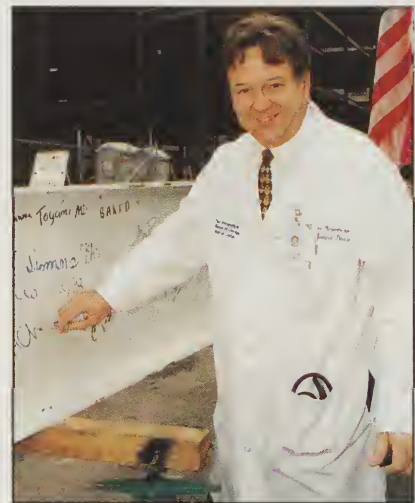
The number of Illinois Part B claims filed annually averages 26.2 million and Michigan averages 26.8 million claims per year, Collins said. "The two states combined would present a challenge to anyone," she said.

The transition is expected to be completed by Aug. 1. Because the processing system will not change and the new carrier has strong experience, Medicare officials expect a smooth transition. "The new contractors have a good understanding of what's

being done. We hope there will be minimal disruption," Collins said. Both companies are veterans of claims processing. Wisconsin Physicians Service has processed Medicare Part B claims for Wisconsin since 1966. National Heritage processes Part B claims for Medicare in northern California, Massachusetts, Vermont, New Hampshire and Maine.

HCFA said the new contractors plan to hire many of the current nonmanagerial staff and maintain operations in the same locations used by the departing carrier, Health
(Continued on page 14)

DURING THE "topping-off" ceremony for a new \$97 million outpatient care center at the University of Illinois at Chicago Medical Center last month, medical director William Chamberlin, MD, adds his signature to a beam. The center is scheduled for completion in 1999.



John McNulty

NLRB sides with physicians

NEXT STEP: Unfair labor practice charge could go to hearing. BY LINDA MAE CARLSTONE

[ROCKFORD] The National Labor Relations Board has sided with the Rockford Physicians' Council in a preliminary step in the council's unfair labor practice allegations against the members' employer, the Rockford Memorial Health Services Corp., triggering the next phase in the complaint process.

The decision stems from a complaint filed last October in which the physician group charged the RMHSC with taking illegal measures to block its efforts to form a collective bargaining unit.

Following an initial investigation, NLRB Region 33 Director Glenn Zipp notified both parties in the dispute that there is reasonable cause to believe that the employer violated the National Labor Relations Act by "interfering with, restraining and coercing employees." The document, dated Feb. 6, calls for a hearing to be set before an administrative law judge employed by the NLRB.

Specifically, the council charged that the RMHSC threatened employees with dis-

charge or the loss of certain job duties if they engaged in activities on behalf of or in support of the collective bargaining unit. A second charge of interference stated that the RMHSC solicited employee grievances and promised to rectify them by inviting five employees to become members of a physician leadership group.

Last month, the labor board informally notified both parties of its decision and proposed a settlement whereby the RMHSC would remove all nonsupervisory employees from the physician leadership group and it would not solicit grievances nor promise to redress grievances.

The RMHSC declined to negotiate a settlement with the NLRB, a move the council said demonstrates their "absolute intransigence."

"The Rockford Physicians' Council has repeatedly requested an opportunity to discuss issues with RMHSC in a positive and constructive fashion. These overtures have been persistently rejected," said RPC

(Continued on page 14)

Edgar outlines achievements in delivery of health services

SERVICES: Medicaid improvements, women's initiatives included in State of the State address.

BY JANE ZENTMYER

[SPRINGFIELD] In his final State of the State address as governor, Jim Edgar said the state's improved finances and increased efficiency of services, including health services, are among the top accomplishments of his administration's past seven years.

"We've prepared Illinois to enter the 21st century capable of meeting any new challenges that lie ahead," the governor said Jan. 28 before a joint session of the General Assembly. The state's preparations included eliminating "a mountain of Medicaid debt. ... And, yes, we have been paying and will continue to pay our bills on time."

Currently, Medicaid pays physicians, hospitals, long-term care facilities and others in about 25 days or less, said Dean Schott, spokesman for the Illinois Department of Public Aid. That's quite an improvement from fiscal 1994 when the state had a \$1.3 billion backlog of Medicaid bills and took at least 100 days to pay its bills.

Under Edgar's direction, the state has also begun to streamline health and social services delivery through the newly created Illinois Department of Human Services. "Programs and services once scattered among a half-dozen agencies are now being administered and delivered by a single agency," Edgar said. "A family that turns to government for assistance now deals with a case manager who can tap into several different services needed to address the problems of the family as a whole."

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SIU shares learning technique in India

EDUCATION: Everybody gains from problem-solving experience. BY JANE ZENTMYER

[SPRINGFIELD] The planning and waiting took more than a year, but six Southern Illinois University School of Medicine students and two faculty members finally got to their destination: Jawaharlal Nehru Medical College in Aligarh, India. This trip, said Carl Getto, MD, dean and provost of SIU medical school, let SIU share "something that we have found of great value to us." They also got a lot in return.

That "something of great value" to which Dr. Getto referred is problem-based learning, a teaching technique SIU has pioneered, whereby students enhance their understanding of clinical issues by solving problems in small groups using available resources. The SIU students shared their experiences with problem-based learning with the students and faculty who gathered in Aligarh in November for a two-day workshop.

This learning technique differs from the traditional learning process of memorizing what's said in lectures in that it "builds on information you already have and allows you to retain information because you have to use it to solve a problem," Dr. Getto said. "Most people, especially physicians, will retain information better when it is used in the active solution of the problem."

So, for example, a student group will be assigned the case of a patient who presents with a fever. "As they read about this person, they will start trying to figure out why does this person have a fever, what does it mean to have a fever, what does it mean to get a fever, what's the physiologic control of temperature, what causes fever," Dr. Getto explained. "And then each of those answers will suggest trails to follow."

At the India workshop, each of the six American students – Kristin Herman, Nancy Taft, Senait Fisseha, Jyoti Patel, Michelle Lockwood and Jeanine Patton – became a tutor for a group of Indian medical students while the Indian faculty members became observers.

When the workshops began, a number of things became apparent immediately, Dr. Getto said. SIU typically groups together students of comparable educational levels, so first-year students will be grouped with other first-year students. But the India groups combined students



SIU medical student Michelle Lockwood (far right), a junior from Peoria, listens as Indian medical students use the problem-based learning process to work through a clinical issue during a workshop in Aligarh, India.

from different levels, which "meant there was a relative range in terms of what the students knew," Dr. Getto said.

The Indian students, just like many of their American counterparts who first experience problem-based learning, also needed to challenge the school hierarchy, which meant not being afraid to question a professor or a student with more schooling. "It's a whole different process than they're used to," said SIU student Herman. "They're not used to speaking out and saying that something a second- or third-year [student] said is wrong. That happens to a lot of medical students, but a part of the group process is to risk being wrong and learn from mistakes."

For example, SIU student Taft said that one of her students spent at least five minutes talking about Parkinson's disease, which was the wrong diagnosis for the clinical case. "He was wrong, and I knew he was wrong, but I let him talk for a while," Taft said. "And then another student who was an undergrad spoke up and said, 'You know, I read something different,' and kind of challenged him on that. Then the whole group got involved in the discussion."

The faculty observers later asked why she let the student talk for so long about the wrong diagnosis. "I did it because we always remember better when we're wrong and get corrected," Taft said.

By the second day, the students had

caught on to problem-based learning, Herman said. Students within each group had pooled their knowledge the previous evening to work through their clinical problem. The third-year students, for example, shared their expertise with the second-year students. One student cornered an orthopedic surgeon to get a question answered, Dr. Getto said.

Many of the Indian medical school faculty members initially expressed doubts about problem-based learning

that mirrored many of the concerns American faculty members often express, said Satu Somani, a professor of pharmacology and toxicology at SIU who was part of the SIU group.

For example, Herman said, faculty members asked her how students learn about the basic sciences from a clinical case. On the workshop's second day, she showed how that is possible if students ponder questions such as, "Do you see how you can use sinusitis to get to the anatomy of the skull?" Doubts among the faculty began to disappear once the students showed signs of progress.

Although the SIU students traveled to India to share the problem-based learning technique, they learned a lot themselves, making their hard work to get there well worth it. Students raised money from fund-raisers and contributions to cover most costs. ISMS contributed funds, along with the American Medical Association, Abbott Laboratories, Novartis Pharmaceuticals and Pfizer Inc.

The trip's focus wasn't all problem-based learning. The students also learned about alternative medicine by visiting a yoga master and touring a pharmacy that produces herbal medicines. They toured a Bombay hospital that is the equivalent of any major U.S. teaching hospital.

"We had an absolutely amazing time," Herman said. "It's just an incredible opportunity – one that I'm very thankful I was able to have through the generosity of everybody who donated money and supported us."

Porter honored for support of medicine, research

[WASHINGTON] Rep. John Porter (R-Ill.) has won the 1997 Excellence in Public Service Award from the Association of American Medical Colleges for his support of academic medicine and leadership in "championing the National Institutes of Health."

Porter, who serves as chairman of the U.S. House Appropriations Subcommittee on Labor, Health, Human Services and Education, has obtained substantial increases in funding for biomedical research through NIH.

This year, Porter wants to double the \$13.5 billion allocated to medical research, bumping it to \$27 billion over the next five years, a move supported by House Speaker Newt Gingrich (R-Ga.). In 1997, the Senate voted 98-0 to endorse this goal, but did not say how the money should originate. NIH officials have told

Congress that the bottom-line goals of managed care organizations have reduced the amount of money available for clinical trials of promising treatments, according to the New York Times. Academic health centers have used the now-limited surplus money from patient care to supplement federal funding for such efforts.

Porter has said his support of medical research funding stems from his observations of his father's battle with polio, a disease that now essentially no longer exists because of medical advances.



Rep. Porter

Surety bonds a must? Don't be fooled

[WASHINGTON] Beware of bond companies trying to cash in on a possible Medicare ruling that could require some physicians to purchase surety bonds, the American Medical Association warns.

The yet-to-be-finalized ruling by the U.S. Health Care Financing Administration addresses who must purchase surety bonds in order to distribute durable medical equipment. The bonds are not required for physician office-based medical services.

Some physicians have reported to the AMA and ISMS that bond sellers are urging them to purchase the bonds immediately. That's premature, according to an AMA spokesperson.

Warren Lowry, MD, a Rockford urol-

ogist, said he received a solicitation from a bond company implying he needed to buy the bonds. "It was misleading to me," he said.

It is true that HCFA is considering a requirement that anyone using supplier identification to bill Medicare must post a surety bond, the AMA said. But HCFA will not require the purchase of surety bonds by physicians' offices that distribute durable medical equipment until the regulation is final.

HCFA is accepting proposal comments through March 23; these will be considered before it issues a final ruling. Once the regulation is final, each supplier will be informed about the requirements for the bonds.

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Illinois medical schools see continued shortage of cadavers

BEQUESTS: Physicians can encourage donations.

BY SUZANNE SCHOENFELT

[CHICAGO] The demand for cadavers for medical-school study may be growing each year, but cadaver donations are not keeping up, according to Russell Dovichi of the Chicago-based Anatomical Gift Association of Illinois. Each year the AGAI receives about 650 donations, whereas about 1,000 donations currently are needed. Cadavers donated to the AGAI are used strictly for education and study, Dovichi said. They go to medical schools, mortuary science programs and junior and community colleges.

Until recently, the AGAI solicited donations strictly through word-of-mouth, but now it has begun advertising in Chicago's daily newspapers. That, as well as raising its visibility level at nursing homes and through church groups, has helped, Dovichi said. Still, he added, "the increase in real donations will probably only be seen five to 10 years down the road."

benefits, meaning the goodwill one feels by having contributed to medical science." He added, "medical scientists and researchers donate their bodies to science because they are aware of the need and humanistic benefit."

Increased demand can be attributed

to the advancement of medical technology, to more emphasis on medical research and to more advanced surgical procedures such as in endoscopic surgery, which have led to a greater number of surgery residents, said Larry Cochard, vice president of the AGAI board. Physicians know that nothing can inform students the way cadavers do, said Cochard, an assistant professor of medical education at Northwestern University in Chicago, where he coordinates the anatomy labs and teaches anatomy and embryology.

"The cadaver is still the best way to learn," he said. "Dissecting the human

body is a very powerful learning experience that cannot be duplicated. This traditional rite of passage in medical schools is multipurpose and necessary."

The AGAI is working to give people the opportunity to donate their bodies for medical education in the same way they can for organ donation. Checking the "whole body donor" section of a driver's license application, though, does not work. That "implies that a person's whole body may be harvested for organ donation," McNulty said.

For information on donating or how physicians can get involved, call the AGAI at (312) 733-5283 or (800) 734-5283. ■

Dissecting the human body is a very powerful learning experience that cannot be duplicated.

The AGAI believes that physicians have a role in increasing donations by encouraging their patients to donate. In addition, "the AGAI board has been trying to recruit retired physicians to visit convalescent homes, nursing homes and hospitals to distribute fliers, answer questions and promote donations," said John McNulty, course director and a board member at Loyola University Stritch School of Medicine in Maywood.

A medical school's cadaver shortage can be troublesome, he pointed out. "About 10 years ago, Loyola obtained cadavers from another Midwestern university," he said. "The cadavers had been prepared with a high solution of formalin, and the smell was unpleasant. We hoped we wouldn't have to look elsewhere for cadavers again."

Public misunderstanding contributes to the shortage, McNulty said. "The population at large is not aware of the tangible benefits, meaning decreased funeral costs, as well as the intangible



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REPORT for Illinois Physicians

MAJOR ORGAN TRANSPLANTATION

Blue Cross Blue Shield of Illinois (BCBSI) continues to require its members to utilize "Plan Approved" Institutions to receive services for Heart, Lung, combined Heart/Lung, Liver and simultaneous Kidney Pancreas transplants. As of January 1998, BCBSI no longer independently reviews institutions to establish a local "Approved" transplant network but has fully integrated its network with the Blue Cross Blue Shield Associations' Blue Quality Centers for Transplant (BQCT) (formerly the National Transplant Network). All Illinois "Plan Approved" transplant centers must now be members of the Associations' BQCT.

To be included in the BQCT institutions must meet stringent quality standards developed by independent experts. Each institution also must undergo a site visit. Standards all institutions must meet have been set for:

- Transplant Program Duration
- Volume of Transplant Procedures
- Patient Survival Rates
- Physician and Surgical Team Experience
- Documented Quality Improvement Initiatives

All institutions are surveyed on an annual basis to confirm that they continue to meet BQCT standards.

The Association collects data on network utilization and cost to evaluate how each institution meets the needs of each transplant recipient. Additionally this data is utilized to evaluate the validity of the survey and to update the survey criteria as needed. BCBSI works closely with the Association to collect this data.

Any specific comments or questions concerning BCBSI's Plan Approved Transplant Institutions can be directed to Bob Fucik, MD, at 312-653-7924.

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EDITORIAL

The next logical step for tort reform

The Illinois Supreme Court's decision to overturn *Best vs. Taylor Machine Works*, the case that tested the state's 1995 tort reform law, could have given political naysayers reason enough to say that the fight for tort reform is over.

In fact, the effort to bring civil lawsuit award caps to Illinois has been going on for more than 20 years. Tort reform could have driven down the costs of medical care and increased access for Illinois patients. In our battle for tort reform, the next logical step is the polling booth during the March 17 primary election.

Certainly, the *Best* case cannot be appealed to the U.S. Supreme Court, for several reasons, including the fact that the ruling was based on state constitutional issues and not federal issues. With an appeal out of the question, supporters of tort reform must help elect court justices who understand the concerns of physicians and business professionals – and who understand that their role is to interpret law, not make it.

The primary election is an outstanding way to renew our commitment to tort reform. While no Illinois Supreme Court justice positions are open in this election, there are vacancies in three state appellate courts: two in the 1st District Appellate Court, which encompasses Cook

County, and one in the 4th District Appellate Court, which includes 30 counties in central Illinois.

The Illinois State Medical Society Political Action Committee Council has examined the qualifications of these candidates and is contributing to the campaigns of the judges who most deserve physician's support.

Considering that the state Supreme Court hears only 10 percent of cases appealed to it, the vast majority of the final decisions in state court cases are made by appellate courts.

It's also important to note that the appellate courts are often a stepping stone for jurists who may someday be elected to the state's highest court. Justices with experience as plaintiffs' attorneys are more likely to strike down tort reform laws than jurists with experience defending physicians or businesses.

It would have been folly to depend upon one decision to make or break tort reform. *Best vs. Taylor Machine Works* was a truly important decision, but it also presented physicians, business leaders and other professionals with an important opportunity to establish solid groundwork for stronger tort reform efforts. By contributing to IMPAC and voting for physician-friendly justices, we can continue our important work for tort reform.

PRESIDENT'S LETTER

The case for collective bargaining

Jane L. Jackman, MD



With the trend toward employment, the need for collective bargaining units such as the RPC will increase.

Cesar Chavez, Leonard Woodcock, Mary Jones, George Meany, Walter Reuther ... and Marcus Welby, MD? Doctors carrying union cards? If this seems an unlikely proposition to you, a recent American Medical Association report estimates that 14,000 to 20,000 physicians are currently members of unions across the country. With 48 percent of physicians now serving as employees of hospitals, clinics, medical schools and health maintenance organizations, this number is expected to grow. In fact, the traditional labor unions are looking to the health care sector for new recruits (and that includes doctors!) to bolster their sagging numbers.

Until recently, most physician unions could be found in California and along the East Coast. However, the nation is watching closely what is happening on our own doorstep in Rockford. A group of hospital-employed physicians at the Rockford Clinic formed a collective bargaining unit last year with the help of the AMA. Calling themselves the Rockford Physicians' Council, their main concern was that as employees they did not have enough involvement in important decisions affecting patient care at their clinic. The doctors have agreed they will not withhold patient care, that is, they won't strike, as a bargaining tool with the hospital administration. They also plan to avoid a confrontational, disruptive approach with management whenever possible, since their main concern is to obtain more autonomy over clinical decision-making.

The AMA, through its new Division of Representation, provides the RPC with legal services and advice including the services of labor lawyers. ISMS has also endorsed and commended the organization. The Winnebago County Medical Society, in turn, has provided a forum for physicians to be heard. Organized medicine is watching closely what is happening in Rockford since the same situation is likely to arise elsewhere in our state and throughout the country. The RPC is unique as a collective bargaining unit because it is a private

organization guided by traditional medical ethics and completely unaffiliated with traditional labor unions such as the AFL-CIO.

Last year, the RPC physicians filed a complaint with the National Labor Relations Board claiming that their employer, Rockford Memorial Health Services Corp. violated federal labor law when it tried to interfere with the RPC's organizational attempts. This was upheld by the NLRB this month. The RPC's efforts so far seem to have paid off with more physician input into the management of RMHSC, which should result in better patient care.

Most physicians today feel very stressed under the new health care delivery system. We're angry about the loss of our autonomy, the decline of our incomes (or at least the threat of this) and the viability of our practices. To many of us, the idea of belonging to a union to be our champion is appealing. However, only physicians who are employees have the legal right to collectively bargain with their employers. Most physicians who contract with health plans would be considered independent contractors. Even though health plans can exert substantial economic leverage over us and can also bring inappropriate control over medical decision-making, the option of forming a union to bargain collectively for fees and contract provisions is often not a viable option. However, with the trend toward employment, especially among our younger physicians, the need for collective bargaining units such as the RPC will increase.

For those of you who shudder at the idea of doctor unions, let's look at the changing dynamics of medicine. Our mission is to provide the best care we can to our individual patients. In the case of hospital-employed physicians, collective bargaining – if the participants remember their professionalism – can be the ethical thing to do if it provides the only feasible way of making sure that patient care does not suffer. If collective bargaining is good for patients, then we should support it.

GUEST EDITORIAL

IMPAC needs your financial support

By Jere Freidheim, MD

As Illinois physicians, we are at a critical point in our careers where we must pay closer attention than ever to the actions in Springfield and in Washington. What lawmakers do today in those two capitals will affect the way we practice medicine for many years to come.

As I recently told the medical staffs at BroMenn Healthcare Center and OSF St. Joseph Medical Center in Bloomington, it's imperative to support lawmakers and other candidates who have the background to understand what patients and physicians need. That's why it is crucial to build a strong Illinois State Medical Society Political Action Committee. IMPAC, a separate, voluntary, nonpartisan and nonprofit committee, carefully screens the qualifications of candidates running in state and federal races and provides financial support to the campaigns of individuals who share the views of the medical profession. By helping these candidates, we ultimately help

shape laws and regulations that affect physicians every day.

While many state legislators are somewhat familiar with medical issues, we cannot afford to overlook the need for continuing education. Only three members of the Illinois General Assembly have formal backgrounds in health care: two pharmacists and a physical therapist. While a few are related to physicians, the reality is that about 98 percent of our state legislators took office with no formal knowledge of health care or medicine.

These lawmakers are thrust into a world where their attitudes and actions affect almost every aspect of our professional and personal lives. Like it or not, these elected officials will make the final determination about the quality of our medical practices and medicine's future.

Because the process of electing good candidates is difficult and expensive, your contributions made to IMPAC are

crucial in supporting those who best support the ideals of medical care. Every dollar contributed to IMPAC flows to the campaigns of candidates recommended by local physicians who sit on the IMPAC Council. The IMPAC Council makes final decisions on the distribution and size of the contributions, based on candidates' needs in their races. We cannot let the campaigns of candidates friendly to medicine die on the vine because their coffers do not have the necessary funding.

If we expect to see change in the Statehouse and the U.S. Capitol, physicians must participate in medical political action and legislative advocacy. We must support the campaigns of candidates who understand the tough issues physicians face every day, and who will deal responsibly with these issues. It is up to us to establish lasting relationships of mutual support and consultation with our local lawmakers.

IMPAC's presence in the political arena



Dana Hoback

Dr. Freidheim talks with the medical staffs of BroMenn Healthcare Center and OSF St. Joseph Medical Center in Bloomington Dec. 16.

na is a continuing reminder that physicians need to be active participants – not just spectators. For more information about contributing to IMPAC, call (800) 782-4767 or (312) 782-1963.

Dr. Freidheim is the chairman of the IMPAC Council.

GUEST EDITORIAL

Generation of doctors being forced into early retirement

By Charles Krauthammer

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While President Clinton is blithely proposing a huge expansion of the teetering Medicare program, a looming health care crisis has yet to show up on radar. It is not reflected in statistics because it is just beginning to unfold. We are about to lose a whole generation of our most skilled and senior doctors to early retirement.

Early and, in a way, forced. My evidence is anecdotal, but my sources are good. Over the last few years, I talked with many doctors who graduated med-

ical school in the mid-1970s when I graduated. They are now in the prime of their medical careers and they are desperate to get out.

Typical is a highly respected cardiac surgeon I saw at Christmas. He is in his 40s. His plan is to leave medicine in his 50s. Most ominous is the fact that every cardiac surgeon in his practice group is trying to do the same.

This is unheard of. With all their skill and training, doctors have traditionally stayed on into their late 60s and even beyond. Most of us can remember a family doctor who died while still practicing. It is not going to

be that way anymore.

Why? Three major pressures are driving these doctors to quit. The first is money. These doctors are at the peak of their careers. As they watch similarly situated colleagues in law and business enjoy rising salaries and often exploding compensation, they are getting hammered by the new health care economics. With Medicare decreeing ever-shrinking reimbursement – and insurance companies following suit – they find themselves losing ground even as they work harder. Since 1992, for example, real median income for MDs has fallen.

Last year a member of my family needed surgery for a serious foot injury. It was a very specialized reconstructive procedure that took several hours to perform. The insurance company sent the surgeon a check for \$388. If I'd hired a plumber, he'd have taken home more.

The second cause is the loss of independence. More than money, this is what is driving these senior doctors crazy: some 24-year-old HMO functionary who knows as much about medicine as he does about cartography demanding to know why Mr. Jones, the diabetic in renal failure, has not been discharged from the hospital yet. Dictated to by medically ignorant administrators, questioned about every prescription and procedure, reduced in status from physician to "provider," these doctors want out.

Again, the contrast with sister professions is profound. Lawyers would never put up with a whole layer of bureaucracy telling them how to practice, let alone setting their fees. And no wonder: Lawyers tend to run the legislatures that pass the laws that regulate the professions. Doctors don't.

And finally there is malpractice insurance, another little aggression of the legal on the medical profession. My cardiac surgeon friend devotes about 60 percent of his entire overhead to mal-

practice insurance alone. Some Ob/Gyns pay \$100,000 a year, which accounts for the fact that many towns have no Ob/Gyns at all.

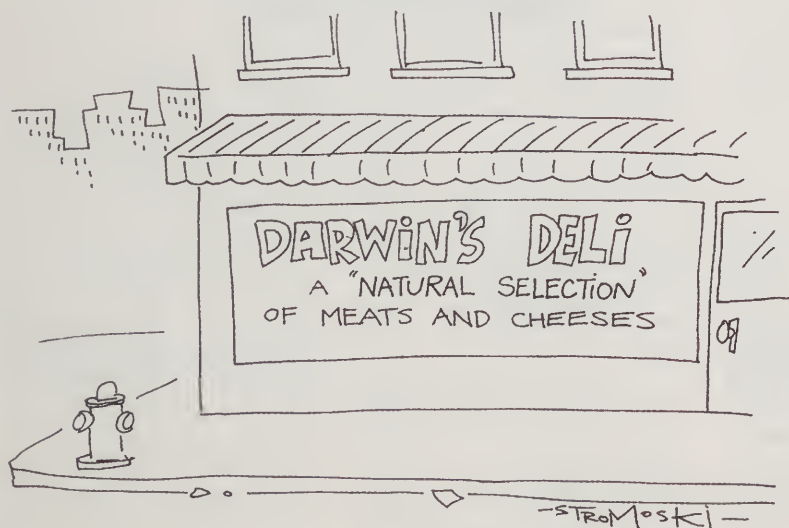
Declining income. Lost independence. Confiscatory malpractice insurance. Put them all together, and you've got pediatricians and surgeons and orthopedists who have had enough. They will work another five or 10 years to put away something for retirement and then leave.

Most people will find it hard to shed a tear for hotshot surgeons who complain about making only, say, \$200,000 a year. But there is something fundamentally unfair in having people give their youth to years of relentless training and sleepless nights, and then changing the rules on them in the middle of the game. This generation of doctors entered a system that promised compensation and independence commensurate with their skills – a deal that, as my doctor friends never tire of pointing out, still holds for lawyers, who charge for every phone chat in six-minute blocks.

Too bad, you say. We need to control health care costs and doctors have to take their hit. Well, it is true that the former rate of growth of health care costs was unsustainable. But we pay a price for the new cost-conscious regime. We may think the price is just rationed care, rushed care, standardized care. But there is another price: inexperienced care, because of the coming dearth of medical elders.

You remain unmoved by the humbling of a formerly sovereign, and often arrogant, profession?

OK. Forget the doctors. Think only of yourself. Think of what a health care system loses when its most experienced practitioners – the ones who, having seen it all, won't panic when a major vessel ruptures during surgery – are gone, and peering into your chest, sweat rolling down his mask, is the junior associate. Learning. On you.



Coming soon:
Dealing with
medical
mishaps

ISMIE Update

Working with difficult patients

Sometimes trying and time-consuming, these individuals require a different type of attention.

BY CHRIS PETRAKOS

Every physician has at least two or three patients who can best be described as difficult. Such patients not only challenge the physician's interpersonal skills, but they can also be a source of problems.

Whether it's an issue of non-compliance, being rude to staff or making unreasonable requests, difficult patients can be disruptive to a medical practice and dangerous to themselves. But good record-keeping and persistence can support a physician's defense if the problematic patients file suit over how they were treated. However, some situations can force a physician to consider terminat-

ing services to be his or her only reasonable course of action with a problematic patient.

Here are four typical problems that difficult patients pose, and some recommendations on dealing with them.

NONCOMPLIANCE

A patient who repeatedly misses appointments for exams and tests could put a physician at risk of a lawsuit unless the physician records the fact that he or she made an effort to urge the patient to show up. David Cromer, MD, chairman of the ISMIE Ob/Gyn Risk Management Subcommittee and a member of the ISMIE Board of

Governors, said that physicians need a system to track appointments. "We have a separate log-book we use if we've asked a patient to come back because she has a problem such as a breast mass or an abnormal Pap smear. If she doesn't show up for an appointment, we make a note in her medical record along with the fact that we've called and left a message." Documentation is the best way for a physician to cover himself or herself against allegations of negligence in the event of an adverse outcome, an ISMIE analyst said.

Once a system is in place, use it. A physician with a tickler system had better make certain it works 100 percent of the time, said Jim Christman, an attorney at Wildman, Harrold, Allen & Dixon in Chicago. "I have seen a physician forget to send a reminder to one patient and the plaintiff's lawyer claimed that since the doctor voluntarily decided to use such a system, he had a duty not to be negligent in following through," Christman said, adding that a physician should be as specific as possible in documenting missed exams. For example, the record should show that a patient was advised to have a mammogram and chose not to, that the exam is important to make a diagnosis and begin treatment, and that the patient understood the recommendation and the consequences of not following the advice.

FRIENDS AND RELATIVES

A patient who is not elderly or incapacitated yet brings a friend or relative along on every office visit not only can disrupt a busy practice, he or she can disrupt the proper diagnosis and treatment. That third party challenges the care and asks for repeated explanations of the patient's condition, which can test a physician's grace and decorum. The solution to this difficult situation may be found



Dave Cutler/SIS

Terminating a bad relationship

Even though it might be tempting to drop a difficult patient from your practice, this reaction should be tempered with the reality that such an action could expose you to extra risk.

Physicians have the legal right to withdraw services from a patient whom they believe is a problem, according to the ISMIE Risk Management self-study guide "Managing Your Risk in the Hospital/At the Office."

To end a relationship, send a certified or registered letter that states you will not see the patient after a specific date, such as 30 days after the letter is postmarked, and encourage or offer to help the patient find a new physician; this interim period gives the patient time to find a new physician. If the patient has a continuing medical problem, the physician must find a new provider or provide sufficient written notification to allow the patient to find a substitute. Offer to make a copy or summary of the patient's record for the new physician

upon the patient's written authorization, the self-study guide recommends.

If the patient does not respond to your letter, ISMIE Risk Management Division analysts said, note that failure in their record and follow up by telephone or in writing. During the interim period described in the letter, "remember, you are responsible for [the patient's] care," according to Bob Baron, an attorney with Rooks, Pitts & Poust in Joliet.

Managed care adds another wrinkle when trying to dismiss a problem patient. Before terminating a relationship, physicians should make certain they understand the protocols that must be followed to avoid allegations of abandonment, according to the risk management self-study guide.

The self-study guide, which physicians can earn six Category 1 CME hours by completing, is available at no charge by calling ISMIE Risk Management at (800) 782-4767 or (312) 782-1654, ext. 1327.

in the extra person's role.

According to Richard Geline, MD, chairman of the ISMIE Risk Management Committee, this type of incident needs to be handled on a case-by-case basis. "Some of this depends on whether the patient or the surrogate is taking the lead during the consultation. If the surrogate makes himself or herself the patient, then deal with the surrogate as you would the patient until the patient turns that person away. But despite the relationship, you have to make sure that the record reflects the recommendations you're making and that the patient understands, regardless of who is taking the lead or how they're acting," Dr. Geline said.

Bob Baron, an attorney with Rooks, Pitts & Poust in Joliet, said that because a privileged doctor-patient communication exists, the physician not only has no obligation to deal with a relative or friend but is bound by confidentiality to refrain

from doing so. Sometimes that is not practical. "The patient will often tell the physician he or she wants to be accompanied by a particular person, and I think that is the patient's right. But if the physician feels that this advocate keeps the patient from having necessary care, the physician has the option of terminating the friend's visits," Baron said.

ABUSIVE BEHAVIOR

When a patient becomes abusive and belligerent with office staff or the physician, the doctor should take the lead and handle the patient with politeness and firmness, said Herb Sohn, MD, attending urologist at Louis A. Weiss Memorial Hospital in Chicago and a professor who teaches physician-patient communication at Chicago Medical School. "I'll talk with the patient and tell them that I'm very sorry they've had a problem with our office staff and that sometimes there are misunderstandings — on

both sides. Usually, I'll go ahead with the examination and say that I'll be happy to talk with them afterwards about the misunderstanding."

Dr. Sohn said he believes it's important not to take sides when the dispute is between a patient and a staff member. "I do reassure the patient that we'll try to do better," Dr. Sohn said. He stressed that neither the staff nor the physician should get into a shouting match with a patient, as tempting as that can occasionally be. "Patients come in with a lot of fears and anxieties, and you have to allow room for that."

Documentation is the best way for a physician to cover himself or herself against allegations.

UNREASONABLE DEMANDS

Busy practices become even more intense when a patient demands an immediate appointment or a prescription without the necessary office visit. Dr. Sohn said it's best to find out in detail why the patient needs a short-notice appointment. The nurse or receptionist knows a legitimate problem requires immediate attention, said Dr. Sohn, whose daily schedule allows time for these types of situations. All physicians should have time set aside during their workday to handle emergencies, according to the ISMIE Risk Management Division.

Some patients can become particular-

ly disruptive if they disagree with a practice's policy of limiting the medication prescribed over the telephone. "I tell patients that it would be unfair if I gave them medication without knowing what's going on and that I'm willing to see them right away. A lot of people think that physicians can prescribe medication over the phone if a patient just has a cold," Dr. Sohn said.

Attorney Christman agrees that physicians need to be wary of prescribing medications over the phone. "I've noticed a trend in the last year or so where a patient will call and say he has a cough and he's congested, and the doctor calls the drugstore with a prescription for Ampicillin. I think a lot of doctors adopt a policy that they'll do this one time, or they'll continue a refill one time. But they won't do it again until the patient comes in for a checkup.

"Where you get into the problem is where you're dealing with something like Vicodin. And the patient goes to two or three different doctors getting prescriptions and none of the doctors knows that the others are also prescribing. So the patient has access to eight Vicodin a day instead of two. In those cases, the smart way to proceed is to have the patient come in, take a history and document it."

MALPRACTICE ROUNDUP

Mother wins minimal award for birth injuries

A California jury found an obstetrician liable for injuries that a large infant sustained during delivery, but awarded the mother only \$8,500 for noneconomic damages, according to the December issue of Medical Malpractice Law & Strategy.

In *Diaz vs. the County of Los Angeles* (University of Southern California School of Medicine), the obstetrician had recommended that the child be delivered vaginally. (The woman's previous child was born by cesarean section.) Following a prolonged labor, the child was born with a fractured humerus, Erb's palsy and a cut lip. The mother's attorney claimed the humerus and lip injuries were caused by the attending medical students' panic in their attempts to deliver the baby. The defendant's attorneys argued that the vaginal delivery was appropriate, but did admit that the lip injury was a departure from the standard of care.

Pediatrician also had duty to parents

Despite the absence of a direct physician-patient relationship, a New York pediatrician had a duty to warn a father about the possibility of contracting polio after his infant daughter received a polio vaccine, according to the Nov. 10 issue of the National Law Journal.

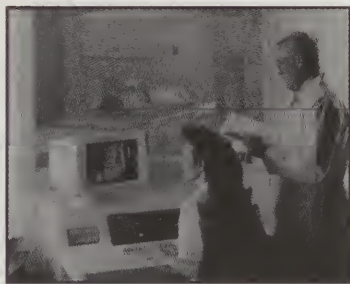
In *Tenuto vs. Lederle Laboratories*, Division of American Cyanamid, the father sued the pediatrician, alleging that he contracted polio because of the physician's failure to inform him of the risk of transmission from the vaccinated baby. The physician moved for summary judgment, saying that the man was not his patient.

The court held that a physician's duty of care to third parties is extended when the physician's services to a patient implicate household members or other individuals who may be at risk because of a relationship with the patient. This is particularly true for pediatricians who must advise their patients' parents, the court said.

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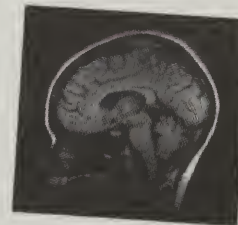
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Candidates map their positions on health issues

Managed care reform remains a hot topic in the 1998 primary election.

BY JANE ZENTMYER

With less than a month to the March 17 primary election, candidates for Illinois House and Senate seats have stepped up their efforts to reach the voters who will help them win their party's nominations. Candidates have found that the need for managed care reform resonates with voters.

"I think voters all over the state have had a not-so-pleasant experience with an HMO or a similar health plan," said Rep. Tom Cross (R-Yorkville), an incumbent who faces political newcomer Wayne Capalby of Yorkville in the 84th District GOP primary. "While I don't think we want to lose sight of the fact that we need to be conscious of affordable health care, we also don't want to lose sight of the fact that quality health care is important."

Although the General Assembly has debated the need for managed care reform, it has yet to send a comprehensive package to the governor. The Managed Care Patient Rights Act, a comprehensive reform bill developed by ISMS, hasn't passed the Legislature. Most of its provisions, however, were folded into H.B. 626, a reform bill the Illinois House approved last year. The Senate has conducted hearings since last spring to debate the merits of various managed care reforms.

The Senate hasn't voted on a comprehensive reform bill yet, but Sen. Dick Klemm (R-Crystal Lake) indicated on an Illinois State Medical Society Political Action Committee questionnaire some of the proposals that he would support. For example, he would back legislation that included a mandate for due process procedures that would allow physicians to contest termination from a plan or that would create a uniform patient complaint resolution process. Klemm is being challenged in the 32nd District Republican primary by Edward Magnus of Barrington Hills, who didn't return his questionnaire before this issue of Illinois Medicine went to press.

Efforts to pass reform legislation may be stalled for now, but voters still seem to be waiting for the General Assembly to do something. "A priority item in my platform is that I would like to continue to work on a managed care patient bill of rights," said Rep. Carolyn Krause (R-Mount Prospect), an incumbent who faces conservative challenger Bob Lowen, also of Mount Prospect, in the 56th District primary. "I've been stressing that as I've been campaigning, and I've received a good reception when I talk about it."

Cross, Krause and several other incumbents who support managed care reform face primary challenges. Some incumbents expect opponents of managed care reform, such as business groups, to take a serious look at their challengers in the primary. Rep.

Rosemary Mulligan (R-Des Plaines), who faces Jim Curley of Des Plaines in the 55th District GOP primary, explained, "It may be a fact that they would support opponents of [legislators] who were out front and leading on health care."

Mulligan, for example, took the lead on an ISMS-supported law that allows women in managed care plans to choose an Ob/Gyn as their principal health care provider. Cross was the lead sponsor of MCPRA when it was first introduced in the General Assembly in 1996, and Krause is the minority spokesperson of the Illinois House Health Care Availability and Access Committee.

All three of these candidates voted for H.B. 626 and have pledged to continue their work toward passage of a managed care reform bill. Rep. Cal Skinner (R-Crystal Lake) from the 64th District is another incumbent who voted for H.B. 626. Rosemary Kurtz of Crystal Lake challenges him in the primary.

Business groups are concerned that the reform proposals will increase health insurance premiums, Mulligan said, adding that very little proof exists to support those concerns. In fact, other states that have enacted comprehensive reform laws have seen minimal – if any – premium increases.

"We have to enlist some of our compatriots who are from the business community to [provide] their lobbyists in Springfield with a little more information as to why [businesses are] accepting rate increases," Mulligan said. Although she's heard cost concerns from the statewide business groups, Mulligan added that members of her local chamber of commerce haven't said anything about them.

On your behalf

In late December, the Illinois State Medical Society Political Action Committee sent a six-page questionnaire to candidates seeking their party's nomination in the March 17 primary.

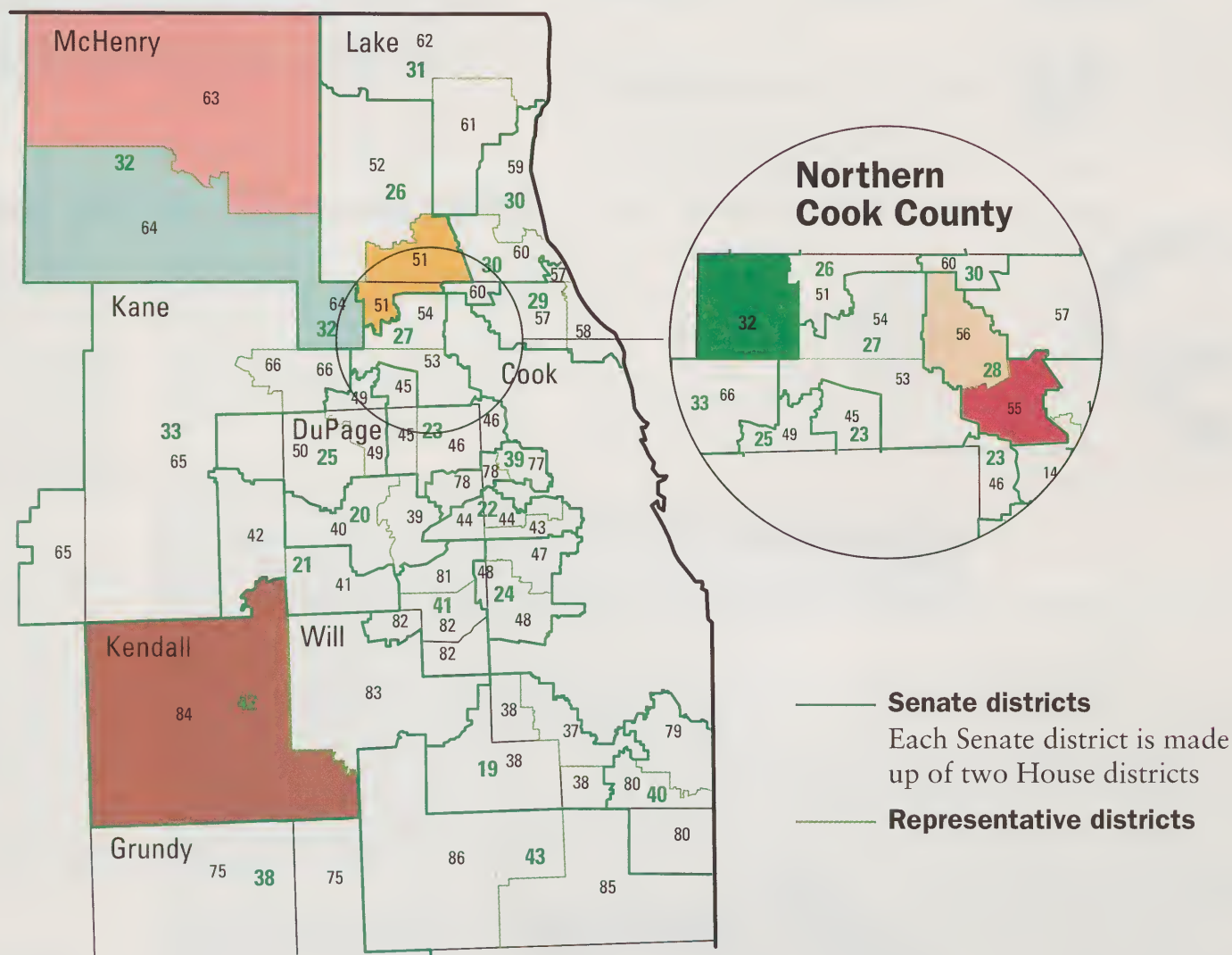
The IMPAC questionnaire asked candidates whether they supported or opposed various positions and policies adopted by the ISMS House of Delegates. Candidates were also quizzed about their views on tort reform, gag clauses and practices, physician profiling, prescriptive authority for advanced practice registered nurses and other issues of interest to physicians.

Physicians can call IMPAC at (312) 782-1963 to get copies of completed questionnaires. IMPAC can also help physicians identify which district they live in and which candidates are seeking election in their districts.

Selected candidates and their districts



Illinois legislative districts - collar counties



Rep. Michael Brown (R-Crystal Lake) was appointed to the Illinois House after former Rep. Ann Hughes (R-McHenry) retired. Like the other incumbents, Brown has indicated he supports a ban on gag clauses and practices, as well as the right for patients to choose a medical specialist to be their principal physician. His GOP primary opponent in the 63rd District, conservative candidate Steven Robert Verr of McHenry didn't return his IMPAC questionnaire by the time this issue of Illinois Medicine went to press.

Brown and the other incumbents also said they backed reform legislation that includes a process that holds plans liable for decisions that deny care and lead to patient harm, a uniform appeals process for patients and physicians to challenge a plan's denial of care and a requirement that plans must notify patients when their physicians' contracts have been terminated. Mulligan said patients also need to know if a managed care plan requires physicians to restrict patient care to meet financial goals.

"Patient care has to come before cost," agreed

Republican Sidney Mathias, the current president of the Village of Buffalo Grove. Mathias is one of four Republican candidates vying for the party's nomination in the 51st District to replace retiring Rep. Verna Clayton (R-Buffalo Grove). The other candidates are Mike Salvi of Long Grove, Ray Ivancic of Inverness and Mark Riefenberg of Barrington.

Political analysts consider Mathias a front-runner in the race along with Salvi, who is a plaintiff's attorney. Salvi is the brother of Al Salvi, a former Republican state representative who is now running for secretary of state, and Pat Salvi, who once served as president of the Illinois Trial Lawyers Association.

As an attorney who has helped clients through bankruptcy proceedings, Mathias has seen how steep medical bills can affect a patient's financial well-being. At the very least, he said, they shouldn't have to worry about the care they receive. "We don't want to be putting in another layer of government to have to deal with this issue, but I think it's important that people get the best care available."

Public Aid delays Link card Medicaid verification plan

[SPRINGFIELD] The Illinois Department of Public Aid has postponed a plan to activate a plastic Illinois Link card that physicians will use to verify Medicaid eligibility. The action cancels a notice sent in January to physicians announcing the cards were being put into effect by April.

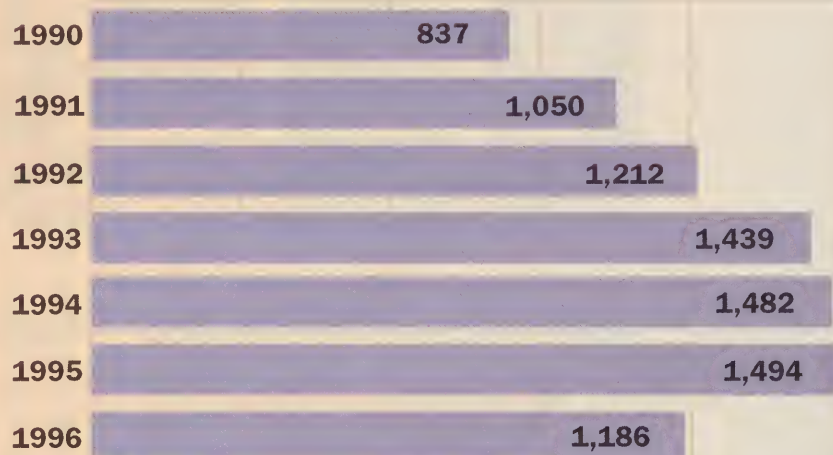
IDPA delayed the activation to address concerns raised by ISMS and other provider representatives about easing the transition to the card. Meanwhile, the paper MediPlan card will continue to be used for eligibility verification.

The Link card is a permanent plastic card embossed with a 19-digit account number and looks like a credit card. It allows the provider to verify eligibility electronically, submit claims, check claim status and receive weekly downloads of claims status information.

To check eligibility with the card, providers will swipe the plastic Link card through a service device similar to those used with credit cards. Providers can also use personal computers to verify eligibility by entering the account number. ■

Illinois AIDS, HIV-related deaths decrease

The number of Illinois deaths from AIDS and HIV-related illnesses fell 21 percent in 1996, the first decrease since the epidemic began in 1981, according to the Illinois Department of Public Health. Though IDPH officials are quick to point out that drug combinations are not a cure, they credit the HIV treatments with leading to the decrease in deaths.



Source: Illinois Department of Public Health

Hot line answers AIDS reporting questions

[SPRINGFIELD] The Illinois Department of Public Health has established a new toll-free hot line to help physicians with questions and concerns about reporting AIDS and HIV cases.

Physicians in Illinois must report HIV infections and AIDS cases within five

days of diagnosis or treatment. Physicians will continue to report cases to their local health departments, but now the hot line will be available for routine questions regarding case reporting and completing the report form.

Illinois physicians and health care providers outside Chicago can call the toll-free hotline, (888) 375-9613, during business hours. Calls will be routed to voice mail during other times or if the line is busy. Chicago physicians should continue to request information and assistance from the Chicago Department of Public Health by calling (312) 747-9812.

Federal funds allocated to the care of HIV and AIDS patients are tied directly to the number of cases reported, so prompt reporting to maintain a complete registry of cases is important, according to IDPH. Illinois received \$12 million in federal aid for AIDS and HIV care and drug assistance for fiscal year 1997. ■

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October 1997

Mark J. Benjamin, Chicago – physician and surgeon license reprimanded and fined \$1,000 for working part-time in a weight control clinic, which exceeded the scope of his temporary licensure for ophthalmology residency.

Santosh Chand, Fairview Heights – physician and surgeon license placed on

probation for two years for failing to report to the Department her resignation of her staff privileges at a hospital while under investigation for failure to submit documentation in a timely manner.

Suresh Chand, Alton – physician and surgeon license placed on indefinite probation for permitting an unlicensed staff member to examine a patient and to authorize and write prescriptions for Xanax, a controlled substance, by signing his name to the prescriptions and using his DEA registration number.

Dong Il Chung, Chicago – physician and surgeon license reprimanded for violat-

ing the terms and conditions of a previously ordered Department probation.

Ajitkumar Dalal, Quincy – physician and surgeon license indefinitely suspended for failure to submit to a physical and mental examination as directed by the Medical Disciplinary Board.

Solomon Greer, Chicago – physician and surgeon license placed on indefinite probation due to outstanding tax liability to the Illinois Department of Revenue for the years 1989-1995.

Phillip Jacobson, Aurora – physician and surgeon license reprimanded for attempt-

ing to use hypnosis on a patient whom he believed had a psychosomatic injury, even though he was not properly trained in hypnosis.

William Janes, Lake Forest – physician and surgeon license reprimanded for having another patient's tissue specimen made up to replace a tissue specimen that was lost.

Woo Young Kim, Sterling – physician and surgeon license probation extended for an additional year for failure to report his suspension of privileges for 30 days at his place of employment.

Stanley J. Kovak, Elmwood Park – physician and surgeon license reprimanded and fined \$500 for unknowingly participating in misleading advertising placed by his previous employer.

Raul J. Puertollano, New York, N.Y. – physician and surgeon license restored to indefinite probation.

Edward Orville Riley, Chicago – physician and surgeon license placed on probation for two years for failure to properly supervise a resident treating a patient with a fracture.

Patrick W. Stodola, Chicago – physician and surgeon license reprimanded and placed on indefinite probation after being disciplined by the U.S. Navy.

John Edward Stopka, Evergreen Park – physician and surgeon license reprimanded and fined \$150 for charging \$75 to furnish a one-page medical record with three lines of writing on it.

Leon Tcheupdjian, Arlington Heights – physician and surgeon license reprimanded and fined \$10,000 for performing procedures that did not meet patients' expectations and allegedly violating advertising provisions of the Medical Practice Act.

November 1997

Luis D'Avis, Skokie – physician and surgeon license suspended pending proceedings before the Department's Medical Disciplinary Board for improper patient-physician relationships.

Aleksandr Krumm, Deerfield – physician and surgeon license placed on probation for two years and fined \$1,000, and controlled substance license suspended for 60 days followed by probation for aiding and abetting the unlicensed practice of medicine and failing to utilize proper protocols in prescribing controlled substances.

Francis I. Lavin, Elmhurst – physician and surgeon license placed on probation for one year and controlled substance license revoked for repeatedly prescribing controlled substances to one patient without legitimate medical purpose.

Edilberto F. Maglasang, Columbia – physician and surgeon license placed on indefinite probation and controlled substance license indefinitely suspended for allegedly nontherapeutically prescribing anorectic and/or tranquilizers in excessive quantities and for extended periods of time to multiple patients.

Arnold Phillips, Naperville – physician and surgeon license placed on probation for three years and fined \$3,000 for charging fees that he failed to disclose to his patients, thereby taking unfair advantage of patients' vulnerability.

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Managed care reforms take center stage at federal hearing

ADVOCACY: Illinois physicians put spotlight on need for change.

BY JANE ZENTMYER

[CHICAGO] State legislatures across the country have researched and developed laws that offer patients some protection from managed care plans, and now the U.S. Congress has turned its attention to the issue. Sen. Carol Moseley-Braun (D-Ill.) conducted a hearing in Chicago Jan. 21 to listen to patients, physicians and others about the need for federal managed care reform.

"We're all asking the question: How do we deal with managed care?" ISMS President Jane Jackman, MD, said. "How do we assure a balance between the needs of patients and their doctors, and the interests of the government, employers, insurance companies and the other payers we rely on to finance care?"

"We have concluded it will require the force of law to preserve the integrity of the patient-doctor relationship — a relationship that is too often threatened by financially driven interference in your doctor's judgment," she said. ISMS developed the Managed Care Patient Rights Act, which is pending in the Illinois General Assembly along with other comprehensive reform bills, to guarantee patients some basic rights, such as the right to clear and understandable infor-

mation from their health plans.

Although Illinois is working on its own reform bill, Dr. Jackman said the Congress can take actions of its own to protect patients. Two bills pending in Congress, including one sponsored by Sen. Richard Durbin (D-Ill.), would close a loophole in federal law that absolves self-insured health plans from liability for treatment decisions they impose on physicians and patients. This exemption is included in the Employee Retirement Income Security Act, which shields self-funded health plans from state regulation. Dr. Jackman said that "closing the ERISA liability loophole is essential to assuring that patient rights actually extend to every patient."

Physicians also testified about the interference they've experienced in their patient-physician relationships. Almost a year ago, six physician groups created the Chicagoland Physician Association to help negotiate contracts with United HealthCare of Illinois Inc. The physician groups joined forces, said Terold Butler, MD, a pediatrician and member of South Shore Medical Group, which belongs to the association, "because of what we feel are the unfair practices of

United HealthCare."

Ronald Hickombottom, MD, a member of the Chicago-based Chatham Health Service Inc., which also is an association member, cited this example: United terminated the group's contract during active negotiations. "At this time, the majority of Chatham's patients were informed that they were being rerouted out of the neighborhood to another physician," Dr. Hickombottom said. "The majority of the patients were outraged." United reinstated Chatham as a primary site after conversations with the group's attorney, he said, but the "damage was already done."

Amy Sheyer, United's director of communications, said the company sent Chatham an updated contract proposal and threatened to terminate the group's existing contract only after it didn't hear from Chatham for four months. Once United heard from Chatham, Sheyer said in a telephone interview following the hearing, it stopped the termination process.

United's contracts do not have gag clauses, added Kaveh Safavi, MD, United's vice president of medical affairs, but the organization asks physicians to keep proprietary information confidential, which is typical for commercial contracts. "Our relationship with the physician community is quite solid, and the best evidence of that is the number of physicians who continue to join and are willing to participate."

Many physicians are forced to sign contracts that contain provisions they

don't like because "when a plan achieves a large enough position in the marketplace, it can afford to issue contracts to physicians on a 'take it or leave it' basis," Dr. Jackman said.

For example, United accounts for 70 percent of South Shore Medical Group's business, Dr. Butler said in an interview. A contract may contain provisions like gag clauses, he said, but they may have to accept it. "Nobody in their right mind would sign [these contracts], but the whole point is if you don't sign you lose 70 percent of your business."

Consumer groups at the hearing also highlighted the need for access to specialists. "Many women diagnosed with breast cancer feel that they are in a fight for their lives," said Susan Nathanson, executive director and chief executive officer of the Y-ME National Breast Cancer Organization. "It is ironic that when the stakes are so high, and when many women are least equipped to do so, many breast cancer patients must also fight their insurance companies for coverage of treatment."

For example, she said many plans require patients to return to their primary care physician for every request to see a specialist. This takes an excessive amount of time, she said, and wears on a person who is ill and undergoing treatment. "These extra visits are unnecessary once the course of treatment is established," Nathanson said.

Dr. Jackman said the market has failed to correct the abuses of managed care plans, and a legislative solution is needed. ■

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Edgar outlines

(Continued from page 1)

The agency, which began operation on July 1, 1997, combined the Department of Alcoholism and Substance Abuse, the Department of Mental Health and Developmental Disabilities and the Department of Rehabilitation Services. Programs from other state agencies, like food stamps and IDPA child care and social service programs, were also folded into IDHS. The consolidation is expected to save \$3 million in fiscal 1998.

Changes in the delivery of mental health services have helped cut in half admissions to state hospitals and reduced the return rate of released patients, Edgar said. For example, each state hospital has a toll-free telephone number by which discharged patients may stay in contact. "We have transformed the system from one that relied heavily on state hospitals and institutions to one where most who need our help are cared for in community-based facilities near their loved ones in settings where they often can work, can be productive [and] can be as self-sufficient as possible," the governor said.

Edgar has also brought attention to women's health issues. He expects an interim report this month and a final report in December from the Commission on the Status of Women, a panel he formed last year to develop strategies to help women overcome obstacles. The commission is looking at equal pay, child care and enforcement of laws on sexual assault and domestic violence, among other issues. ISMS President Jane Jackman, MD, is a commissioner and chairman of the panel's health issues working group.

Also last year, first lady Brenda Edgar initiated the Office of Women's Health to expand awareness of health issues critical to women at midlife, such as osteoporosis, menopause and breast cancer; the governor said this year's budget will fund the office. "This office, one of only five in the nation, will be in the forefront as we encourage women to adopt healthier lifestyles and take care of their health needs," the governor said.

The women's health initiative is modeled after the first lady's Help Me Grow campaign, which used brochures, public service announcements and more to help

more than 100,000 Illinois families get information about children's health and safety issues. The first lady is expected to unveil a comprehensive wellness guide this month that will give mothers practical information on how to keep their babies and themselves healthy through pregnancy and the first two years of life.

To help children from low-income families, Edgar expanded Medicaid in early January to include more than 40,000 uninsured children. "That means they can get the regular checkups, vision and hearing screenings, immunizations, prescription drugs and dental care that are so important [to] growing up healthy," he said.

The governor's action covers uninsured children from ages 1 through 18

with household incomes that are up to 133 percent of the poverty level. Coverage was also extended to pregnant women and their infants with household incomes that are up to 200 percent of the federal poverty level. Federal funds allocated for such expansions in the federal Balanced Budget Act of 1997 will help pay for part of the governor's initiative, and the state will be responsible for the rest.

Edgar said he plans to work with the Legislature to extend the coverage to even more uninsured children. "By covering more children of the working poor, we are helping even more families stay off the welfare rolls," Edgar said. "We are giving those kids a better chance to grow up healthy and strong." ■

New Part B

(Continued from page 1)

Care Services Corp. (formerly Blue Cross and Blue Shield of Illinois). Current Illinois sites include Chicago, Marion and Mattoon.

"It's very likely that many of the same people will be doing many of the same functions," said Richard Baer, MD, medical director of Medicare Part A for HCSC. "Many of the same relationships that providers have established could very well be sustained."

Collins said employee consistency will ensure an experienced staff familiar with local issues. She stopped short of saying there will be no changes at all. "But the goal is to make sure the providers are well-informed of any changes."

John Schneider, MD, chairman of the ISMS Third Party Payment Processes Committee, said the committee will work closely with HCFA and the new carrier to make sure the transition is accomplished with a minimum amount of disruption to physicians. "We want to head off any potential problems."

HCSC announced in December that it is ending its Part A and Part B Medicare contracts. Wisconsin Physicians Service will not contract for Part A, which deals with claims for hospital and home health services. Selection of that fiscal interme-

diary is not expected until May.

The change marks the first time in many years that the two Medicare parts for Illinois will be processed by different companies. The division will make it more difficult to coordinate medical reviews, Dr. Baer said. One carrier that processes both areas has access to both sides of the equation, he said.

If you determine a surgery was medically unnecessary and want to deny Part B, for example, you should also deny Part A payment, he said. "That's hard to do when it's being handled by a different company. We have been doing a lot of work to combine medical review for Parts A and B. That will be split up now."

Collins said it is not unusual in other states for Parts A and B to be handled separately. "It has been that way for years in Wisconsin," she said. ■

NLRB

(Continued from page 1)

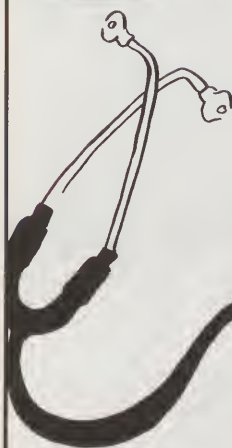
Vice President Frank Nicolosi, MD.

The council does not want to dismantle the leadership group, but it would like the group restructured so that physician members are elected rather than hand-picked by the administration, Dr. Nicolosi said. The council would also like to have the leadership group become a permanent entity rather than something RMHSC could disband at will, he said.

The labor board issued the formal complaint after the RMHSC declined to settle. The next step will be to schedule a hearing on the allegations, a process that could take several months to begin, said Joy Kessler, assistant to Zipp. The judge's decision can be appealed to a five-member board in Washington, D.C., a move that could lengthen the procedure even further, she said.

The unfair labor practice complaint has put on hold a request by the physicians' council to stage an election to become certified as an official collective bargaining unit. However, the council has the option to bypass the unfair labor practice complaint to hold the election, Kessler said. The next step in the election process would be a hearing on eligibility issues, she said. A speedier process than the unfair labor practice complaint, the election hearing could start within two weeks, Kessler said. The hearing will help the regional director determine which doctors are eligible to participate in the election and which physicians are exempt because they are managers or supervisors. ■

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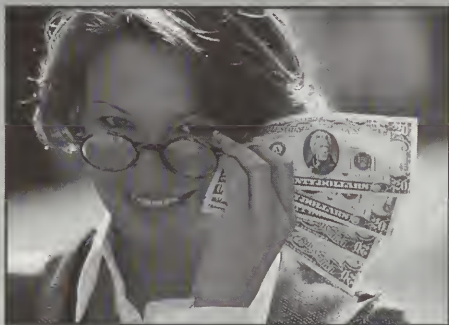


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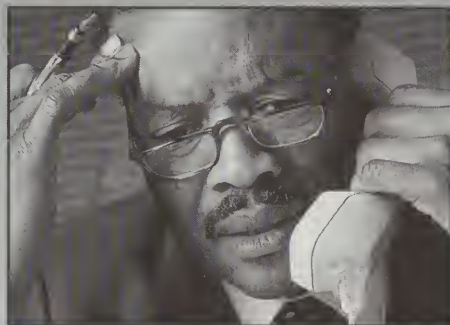


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Health care goes
to Washington

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Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • MARCH 6 1998

ISMS president
keeps in
touch with
members

PAGE 2

APRN licensing sparks debate

DEBATE: Lawmakers face legislation from physicians and nurses. BY JANE ZENTMYER

[SPRINGFIELD] Sen. Doris Karpel's daughter had a low-risk pregnancy and expected a problem-free delivery. During the delivery, however, the umbilical cord was discovered wrapped around the baby's neck. When the baby's heartbeat began to weaken, an emergency cesarean section was performed.

Karpel's daughter and grandson were fine, but their experience made the Roselle Republican think hard about

"this whole idea of allowing people who are not doctors to practice medicine." Both her daughter and grandson could have died without help from those with the medical experience and knowledge needed in an emergency, she said.

"I have some problems with the idea that nurses or midwives can do some things that I believe should be done by doctors," Karpel said. That's why she agreed to sponsor an ISMS-

supported bill that licenses advanced practice registered nurses. The bill was introduced into the Senate as S.B. 1585 on Feb. 19 and introduced into the House as H.B. 3520 on Feb. 17.

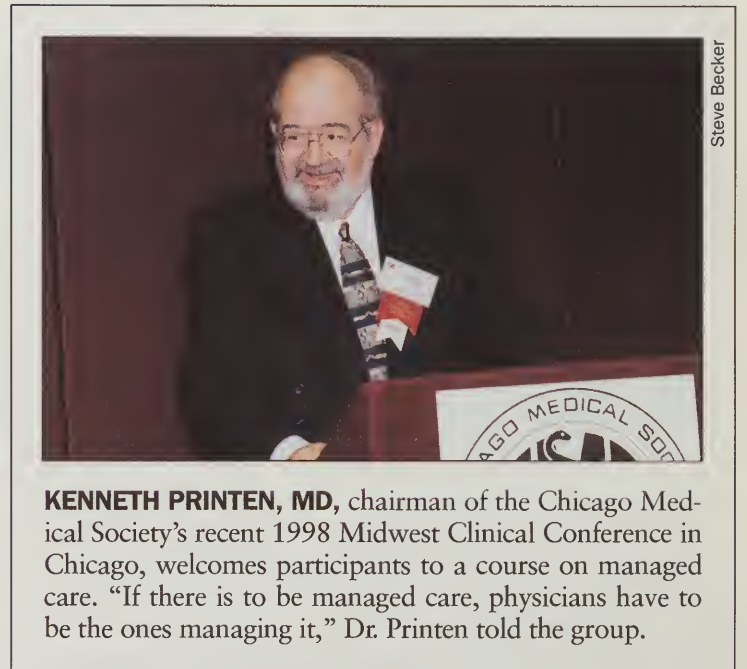
Rep. Angelo "Skip" Saviano (R-River Grove) is the lead sponsor of the House bill. "I'm very hopeful at resolving this issue in a manner that appropriately licenses APRNs and assures access to quality care for all Illinoisans," he said.

The identical bills reflect policies and positions adopted by the ISMS House of Delegates and the ISMS Board of Trustees. Other physician groups, including the Illinois Society of Anesthesiologists and the Illinois Society of Internal Medicine, were involved through their representation on the ISMS ad hoc subcommittee on advanced practice nurses. Among the bill's key provisions are the requirements for a written collaborative agreement between the APRN and the collaborating physician, delegated prescriptive authority for Schedule III to V drugs, and limits on the number of agreements physicians can have with APRNs.

Many of these provisions are missing from the bills supported by the Illinois Nurses Association. Those bills – specifically, H.B. 2921 and S.B. 1253 – are pending. "I think there are probably some good comments and suggestions [from the Medical Society], but there are also some very appropriate recommendations and suggestions from the nurses," said Sen. Bradley Burzynski (R-Sycamore), the lead sponsor of INA's Senate bill.

One method to force a compromise is to move a group's bill through the legislative process, he said. As chairman of the Senate's Committee on Licensed Activities, Burzynski said he knows which bill he would like to move – the one he is sponsoring for the nurses.

Karpel noted, however, that ISMS has already compromised
(Continued on page 12)



Steve Becker

KENNETH PRINTEN, MD, chairman of the Chicago Medical Society's recent 1998 Midwest Clinical Conference in Chicago, welcomes participants to a course on managed care. "If there is to be managed care, physicians have to be the ones managing it," Dr. Printen told the group.

New managed care reform bill introduced into Legislature

ADVOCACY: Measure aims at quality care.

BY LINDA MAE CARLSTONE

[SPRINGFIELD] The drive to lock patient rights into state law recently returned to the Illinois General Assembly in the form of a new and improved ISMS-backed Managed Care Patient Rights Act.

"I'm optimistic that we will put a meaningful managed care reform bill on the governor's desk before the General Assembly adjourns," predicted Rep. Jeff Schoenberg (D-Wilmette), the bill's lead House sponsor. The reasons for legislators to support the bill grow each day with the increasing numbers of people switching to managed care plans, Schoenberg said. "Lawmakers are hearing regularly from their constituents about how current procedures don't work."

The new MCPRA holds true to the same standards as previous ISMS-supported patient rights measures, said ISMS President Jane Jackman, MD. "We want to make sure patients get a fair shake from their managed care insurance companies so they can rest easy that they have protections that guarantee a certain baseline of quality."

The enforcement of these basic patient rights will ensure

that patients receive appropriate medical care in a timely fashion and that such care will not be limited or denied because of economic considerations by insurance companies, she said. "Doctors must be the patients' advocate and there cannot be roadblocks set up by insurance companies to prevent them from doing that," she said.

New this time around are
(Continued on page 14)

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Help available
for people with
disabilities



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IDPR defines how physicians can meet CME requirement

RULES: Medical Practice Act requires 50 hours of continuing medical education annually. BY JANE ZENTMYER

[SPRINGFIELD] A little more than a year after Gov. Jim Edgar signed the amended Medical Practice Act, the Illinois Department of Professional Regulation has released a rule explaining how physicians can fulfill the law's annual 50-hour continuing medical education requirement.

The proposed rule was published Feb. 20 in the Illinois Register.

"We want to make it easy for physicians to meet the requirement," said Joan Cummings, MD, a member of IDPR's Medical Licensing Board and chairman of the ISMS Council on Education and Health Workforce. "We tried to make it compatible with what physicians commonly do."

Physicians must renew their medical licenses every three years, and all current licenses expire in July 1999. Because the CME rule has taken time to

draft and release, physicians will only have to earn 50 hours of CME for the 1999 license renewal cycle, according to Jean Courtney, IDPR's rules coordinator. Any hours earned after July 1997 – the law's effective date – will count toward the 50-hour total.

After the 1999 renewal, however, physicians must earn 50 hours of CME between July of one year and July of the next year, for a total of 150 hours in a three-year licensure cycle, according to the proposed rule. All physicians must fulfill this obligation, including retired physicians and those who live and practice in other states.

A simple way physicians can fulfill the CME requirement, Dr. Cummings said, is to earn the American Medical Association's Physician's Recognition Award. The PRA requires physicians to
(Continued on page 12)

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Tour keeps ISMS president in touch with members

COMMUNICATION: The president is the Society's 'eyes and ears.'

BY JANE ZENTMYER

[PEORIA] Jane Jackman, MD, wears many hats: To her patients, she's a family physician who takes care of them when they're ill. To Illinois physicians, she's president of ISMS. To the media, she's the spokesperson for the association's 18,000-plus members. Some days she plays all those roles, weaving them into a schedule that stretches from early in the morning until late at night.

Recently, Dr. Jackman's day began at her Springfield office with patient visits. The visits were of the usual kind for a family physician – patients with sore throats, diabetes and high blood pressure. She took a break around noon for a telephone interview with a reporter from WCBU, a radio station based at Bradley University in Peoria. After a quick lunch and a few more patients, she was ready to leave for Peoria – the next stop on the president's tour.

Every year the ISMS president visits county medical societies around Illinois to talk about the Society's advocacy efforts and answer physicians' questions.

The tour gives members a chance to meet the president in a less formal setting than the ISMS House of Delegates meeting and gives the president the opportunity to learn what's important to grassroots physicians. Dr. Jackman has visited more than 35 county medical societies as part of the tour since she became president last April.

"When I go around to the counties, my job is to communicate to the members the House of Delegates policy that we are using to work on problems in medicine, especially legislative problems," Dr. Jackman explained. "This year [our agenda includes] pushing for legislation such as managed care regulation and trying to defeat issues such as physician-assisted suicide."

The president often meets with local media as well as physicians when she makes her trips around the state. In Peoria, Dr. Jackman's first stop was at WEEK-TV. She arrived at the station about 4:30 p.m., which gave her enough time to review possible questions on health care with the news



Dr. Jackman (left) responds to questions from WEEK-TV anchors Mike Dimmick and Sabrina Kang during her Jan. 20 appearance on the afternoon news broadcast.

show's anchors. The broadcast began promptly at 5 p.m., and Dr. Jackman waited on the set as the local news stories were presented. Several minutes later, the anchors turned to Dr. Jackman for a short interview about such issues as partial-birth abortion, cloning and managed care reform.

Next stop was the Peoria Medical Society meeting where she talked one-on-one with members before addressing the entire group. Dr. Jackman is an eloquent speaker who often shares personal stories with her colleagues as she travels the state. In a way, sharing those details – like the fact that she decided at age 9 to become a physician after watching her mother battle breast cancer – helps her connect with her audience and sets the tone for the message she's there to deliver.

The message Dr. Jackman has set out to deliver throughout her tenure draws on her experiences as a family physician. It puts the challenges facing physicians in a historical context yet details the need for action to give physicians greater control over their future.

"The most revolutionary change we are currently facing is the way in which health care is delivered. Throughout the ages, medicine and business have coexisted in a necessary state of tension," she said. "Business needed medicine to care for the health of its employees. Medicine, in turn, needed enough business 'know-how' to provide money for a living and for funding education and research. Today, the dynamics between the two are marked by an unbalanced growth toward business rather than a symbiosis."

Dr. Jackman discussed several of the bills pending in the Illinois General Assembly to reform managed care and the need for physicians to express to their legislators their support of some of the reform bills. She also talked about the Illinois Supreme Court's recent decision to

strike down the 1995 tort reform law and the Society's success in defeating a proposed physician profiling bill during the last legislative session. She said, "We have much in common as a medical family, and it is crucial that we work together as a cohesive unit to weather the changes."

Following her speech, audience members asked Dr. Jackman questions about such issues as the Society's support of a requirement that physicians earn 50 hours of continuing medical education annually in order to renew their medical licenses. Dr. Jackman explained that most physicians already earn 50 hours of CME a year, and this requirement reassures patients that physicians have kept up with their education.

Rodney Osborn, MD, the Peoria Medical Society president and an ISMS Fourth District trustee, said the ISMS president can take the messages from physicians to the ISMS Board of Trustees or the House of Delegates. "Because she listens to people around the state, the president has a better understanding of what the members are thinking and saying. The president serves as the eyes and ears of the Society."

If Dr. Jackman can't provide an exact answer to a physician's question at a meeting, she sees that the member will get an answer over the telephone or in a letter. ISMS will try to help physicians with any everyday problems they may experience – either at the meeting or through follow-up conversations afterward.

"A lot of people feel they can't call the Medical Society or don't know how to go about doing it. It's more personal to have the president go there and take an interest in the problem they're experiencing," Dr. Jackman said. "What I'm doing is pulling them in the right direction [to solve their problems] or taking their message back and having someone call them. It makes the value of the Medical Society a little more real and apparent to people."

Telemedicine conference set for March 23-24

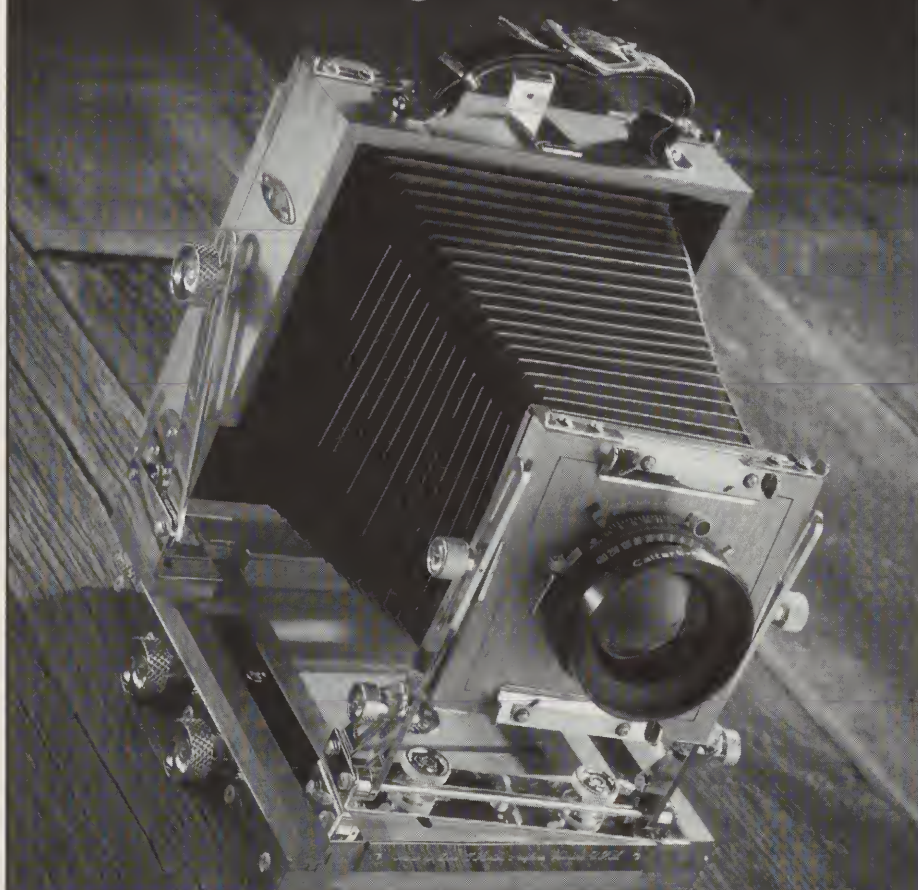
[SPRINGFIELD] The Illinois Rural Health Association will host its second conference on telemedicine March 23-24 at the Crowne Plaza Hotel in Springfield.

The March 23 evening session will feature informal roundtable discussions on such topics as reimbursement issues, staff training and the psychiatric applications of telemedicine. Panels the next day will look at equipment decisions, reimbursement, legal issues and home care applications. A panel featuring Debra Phillips, MD, associate director of the Southern Illinois University School of

Medicine, will look at how physicians have been using the current telemedicine technology, as well as the developments in Illinois' two statewide telemedicine networks.

ISMS is a cosponsor for the conference, along with the Illinois Academy of Family Physicians, the Illinois Hospital and HealthSystems Association, the Illinois Physician-Hospital Institute and the Illinois Area Health Education Centers Program. For more information about the conference, call (217) 383-3206.

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Physicians who default on state loans could lose their licenses

LAW: Appellate court lets stand IDPR nonrenewals.

BY JANE ZENTMYER

[CHICAGO] It may not happen often, but it does happen: Illinois physicians who default on repayments of a type of student loan lose their licenses to practice medicine. The loans come from the Illinois Student Assistance Commission, the state agency that administers the Federal Family Loan Education Program. ISAC, which lends money to Illinois residents who plan careers in a variety of fields, is one of many sources Illinois medical students use to pay for their schooling. And it takes repayment seriously.

Take the case of chiropractor Milton Cully. (Chiropractors, like physicians, are licensed according to the state's Medical Practice Act.) The Illinois Department of Professional Regulation refused to renew his chiropractic license in 1993 after he fell behind in his ISAC loan payments and, despite ISAC's contacting him numerous times, failed to set up a repayment schedule. Cully continued his chiropractic practice for at least 21 months after IDPR opted not to renew his license. He subsequently was arrested and convicted for practicing without a license.

Cully appealed his conviction to the 2nd District Appellate Court in Elgin, arguing that the law allowing nonrenewal of his license was unconstitutional. He said that no rational relationship existed between his failure to repay the loan and the state's interest in public health. The court disagreed.

"It is reasonable for the state not to renew a medical license when the licensee culpably defaults on an educational loan and the loan has enabled the licensee to pay for the education that is a prerequisite for the license," the court wrote in its Jan. 17, 1997, decision. "If the licensee culpably does not repay the loan, this calls his moral character into question and could constitute conduct that defrauds or harms the public."

While this case involved a chiropractor, physicians also face losing their license if they don't repay their state loans. Other professionals, like nurses and lawyers, face similar disciplinary action if they default on their ISAC loans, according to IDPR.

ISAC grants almost 400 million loans annually to Illinois residents, said Kathy Rooney, ISAC's deputy director. "There are many other types of loans that doctors could take out, which we wouldn't have any role in," Rooney added. "Some

of those could be federal loans that we don't guarantee, so we wouldn't have the authority to exercise any kind of disciplinary action regarding those loans. They could also have gotten private loans from the lender, which we wouldn't have any authority to help collect on."

But it does monitor its own transactions. ISAC will begin efforts to prevent default on its loan when an individual makes no payments for 90 days. Commission representatives will make telephone calls and write letters to urge the loan recipient to contact ISAC for help. People are not considered in default of their ISAC loan until 180 days have passed without payment, Rooney said. As a last effort, ISAC sends a letter notifying the borrower that he or she may not get another license. That notification is usually strong enough that the individual will set up a repayment schedule. If the issue is not resolved when a three-

year licensure cycle begins, IDPR can refuse to renew the license.

That doesn't happen often, primarily because few physicians default on their loans. In 1996, IDPR refused to renew the medical licenses of only eight physicians for defaulting on their loans. Only 11 physician licenses weren't renewed for this reason in 1993, with 17 nonrenewals in 1990 and eight in 1987.

No one has defaulted on loans offered through the ISMS Medical Student Loan Program, for example. Since its inception with the 1983-84 school year, the program has lent more than \$1.9 million to 945 borrowers. ■



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REPORT for Illinois Physicians

ILLINOIS MEDICARE Screening PAP Smear and Pelvic Examinations Effective January 1, 1998

Screening Pap Smear

The Balanced Budget Act of 1997 provides for coverage every three years of a screening Pap smear, or more frequently for women (1) at high risk for cervical or vaginal cancer, or (2) of childbearing age who have had a Pap smear during any of the preceding three years indicating the presence of cervical or vaginal cancer or other abnormality. This smear must be ordered by a doctor of medicine or osteopathy, or other authorized practitioner, under one of the following conditions:

- The beneficiary has not had a screening Pap smear test during the preceding three years (use ICD-9-CM code V76.2, special screening for malignant neoplasm, cervix), or
- There is evidence (on the basis of her medical history or other findings) that she is of childbearing age and has had an examination that indicated the presence of cervical or vaginal cancer or other abnormalities during any of the preceding three years, or that she is at high risk of developing cervical or vaginal cancer (use ICD-9-CM code V15.89, other specified personal history presenting hazards to health).

The term "woman of childbearing age" means a woman who is premenopausal, and has been determined medically to be of childbearing age. Payment is **not** made for a screening Pap smear for women at high risk or who qualify for coverage under the childbearing provision more frequently than once every 11 months after the month that the last screening Pap smear covered by Medicare is performed.

The Part B deductible for screening Pap smear services paid for under the physician fee schedule is waived.

Screening Pelvic Examination

The Balanced Budget Act of 1997 also provides for coverage of a screening pelvic examination. This examination does not have to be ordered by a physician or other authorized practitioner. However, it must be performed by a doctor of medicine or osteopathy, or other authorized practitioner.

Payment may be made for a screening pelvic examination performed on an asymptomatic woman only if she has not had a screening pelvic examination paid for by Medicare during the preceding 35 months following the month in which the last Medicare-covered screening pelvic examination was performed unless:

- There is evidence that the woman is at high risk (on the basis of her medical history or other findings) of developing cervical cancer or vaginal cancer. (Use ICD-9-CM code V15.89, other specified personal history presenting hazards to health.)
- The woman is of childbearing age, and such an examination indicated the presence of cervical or vaginal cancer or other abnormality during any of the preceding three years.

The Part B deductible for screening pelvic examinations is waived. Pelvic examinations will be paid under the physician fee schedule.

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EDITORIAL

The last phase of life

The physician's traditional role, of course, is that of a healer. In the last phase of life, a patient's needs change so that the physician's most important role is that of a comforter. The American Medical Association has put together a worthy document entitled "Elements of Quality Care for Patients in the Last Phase of Life." More than just a series of guidelines, the document offers some reminders of how physicians can bring peace and dignity to dying patients. To that end, the dying should expect eight elements of care from their physicians, their health care institutions and their community.

Among these are the opportunity to discuss and plan for end-of-life care, including the chance to talk about treatment preferences and to prepare living wills, according to the document. Physicians should be skilled in managing pain, fatigue and depression, using the skills of specialist colleagues and honoring patients' preferences for withdrawing life-sustaining intervention. These patients also need to be assured that their physicians will not abandon them, even after care has been transferred to a specialist.

Patients also want the reassurance that their dignity and personal goals will be the top priority of their physicians. If they want attention to their spiritual needs, to complete a major unfinished task or to die at home or

another place of personal meaning, the wish should be attended, the AMA piece explains. Patients with terminal illnesses also have the right to be assured that the burden to their families and others will be minimal during their last months, with the assurance they can receive palliative, hospice or home care so their illnesses will not overwhelm their relationships. There should also be the assurance that health care providers will help their families and friends through the initial stages of mourning and adjustment. This can be as simple as a bereavement letter or attention and referral for care of the increased physical and mental health needs of those suffering the loss.

ISMS participated in an amicus curiae brief filed by the AMA in opposition to the legalization of physician-assisted suicide when the issue went before the U.S. Supreme Court. During its 1997 Annual Meeting, the ISMS House of Delegates last year approved a resolution stating that it is imperative to identify factors related to physician attitudes, patient feelings and the health care system that pose barriers to providing end-of-life care. ISMS agrees with the ideals expressed in the AMA's one-page document and members are encouraged to ask for a free-of-charge copy from the AMA Ethics Standards Division by calling (312) 464-5619.

PRESIDENT'S LETTER

Let's set the facts straight about APRN licensure

Jane L. Jackman, MD



We strongly disagree that APRNs are interchangeable with physicians.

Have you been lobbied recently by your local nurses to support H.B. 2921 and S.B. 1253? Are you being asked to call your state representatives and senators to pass these bills? If you work with advanced practice registered nurses, chances are you may have been told that ISMS is stonewalling on the licensure of these health care workers. Judging by some of my mail, there appears to be some confusion about our position on the licensing of APRNs.

We agree that APRNs should be recognized under statute in Illinois – in fact we recently had our own bill introduced to do just this, following the Illinois Nurses Association action on H.B. 2921 and S.B. 1253. Over the last two years ISMS had been negotiating with the INA on these issues, mainly through our Council on Education and Health Workforce. Many compromises on both sides have been achieved, but we have further to go to reach an amicable solution and significant disagreements remain. The media and even some legislators portray these disagreements as a class struggle between the "powerful, well-heeled" doctors' lobby and the "underdog" nurses' association. Some even choose to see the issue as a feminist cause – (mostly) female nurses no longer willing to be the subordinates of the (mostly) male medical profession. We see it as a patient safety issue. Today, with Florence Nightingale increasingly likely to be Frederick Nightingale and Marcus Welby, MD, just as likely to be a Martha Welby, MD, I hope we can see the real issues clearly and cut through the rhetoric. We need to concentrate on collaboration and teamwork to find a safe solution that fits the needs of Illinois patients.

Essentially, the INA bill would allow APRNs independent practice, especially nurse anesthetists. While we agree with the nurses that these new, well-trained nurse specialists are a welcome addition to the health care team, we strongly disagree that APRNs are interchangeable with physicians.

As professionals we differ from each other, not just in the length

and content of our training, but in our patient skills and focus. One profession is not "better" than the other, just different. Ideally, doctors and APRNs should complement each other. This is why we need a written collaborative agreement. It is also why it is important to only allow collaborative relationships between a doctor and an APRN in the same field of practice. A physician who does not practice obstetrics, for example, would be unable to advise and collaborate with a nurse midwife.

ISMS believes that to ensure true collaborative relationships, limits should be set on the physician-to-APRN ratio. The INA doesn't think this is necessary. We disagree. Medicine is becoming increasingly focused on the bottom line. If there are no ratios, what is there to stop an enterprising insurance company from hiring multiple APRNs as "gatekeepers"? Our proposed ratio is the same as that in the new Physician Assistant Act – two APRNs (or four nurse anesthetists) or their full-time equivalents to one physician.

Independent practice for APRNs is being touted as the solution to the health care access problems in rural and inner city areas. Noble as this may be, we think APRNs would be no more likely to settle in these areas than doctors.

We hope these disagreements will be settled amicably and quickly, especially because both parties should be on the same side when caring for patients. I find it ironic that the nursing profession which is currently decrying the use of lesser-trained technicians in hospitals by stating that "every patient deserves to have a fully trained RN involved in their care," is now balking at our statement that "every patient deserves to have a fully trained physician involved in their care."

I certainly hope you will call your state legislators about APRN licensing. But before you make that call, call the Medical Society at (800) 782-ISMS and get the facts. We need your political activism, but you need accurate information on the issues.

GUEST EDITORIAL

Assistance for people with disabilities

By Ed McManus

For Illinoisans with severe physical and mental disabilities, two programs offered by the Illinois Department of Human Services have made it more feasible for them to live in the comfort of their homes instead of in the care of institutions. Since 1990, the state has offered the Family Assistance Program to the parents of developmentally disabled youngsters and the Home-Based Support Services Program to mentally and developmentally disabled adults. Physicians can help families keep these individuals in their homes by letting parents and other family members know these programs are available.

The Family Assistance Program provides a monthly \$494 check to families with children with severe developmental disabilities or severe emotional disturbances. The money may be used for respite care, therapy, medical expenses, family counseling, home modification, special vehicles and equipment. A child must live with a biological, adoptive or foster parent or a guardian to be eligible, and the household's taxable income must be less than \$50,000.

For adults with severe developmental disabilities or severe mental illness, the Home-Based Support Services Program gives up to \$1,482 each month for goods and services related to the disabilities. Participants are linked to a community agency for help in selecting services such as personal care, therapy, training and assistance in self-care, job-seeking and transportation. The families also may use the funds to buy medicine, nutritional supplements, adaptive equipment, home modifications and other items. Adult applicants must live in their own home or with a relative or guardian and must be eligible for federal Supplemental Security Income or Social Security Disability Income.

Forty-nine states now offer family support programs for children with developmental disabilities, but Illinois is one of the few with programs for individuals with mental illness. An

advisory council that includes individuals with disabilities and family members helps IDHS operate the programs.

Do the programs work? Evaluations by the University of Illinois at Chicago and the University of Chicago said they do. A UIC study found that adults involved in family support demonstrated better living skills and improved relations with others than individuals with disabilities who did not participate. Twice as many families of non-participating adults with developmental disabilities told UIC researchers that they planned out-of-home placement than families of participants. Similarly, UC researchers found that many more families of children who were not in the Family Assistance Program had placement plans, compared with participating families.

The cost for family support compares favorably to state-funded out-of-home residential placements. For example, the annual cost for a child in the Family Assistance Program is \$5,928, while the average cost for an individual involved in Home-Based Support Services is \$11,500. By comparison, the average cost for a single placement in a Community Integrated Living Arrangement is about \$38,800 and the cost in a state-operated developmental center is about \$80,000.

The two programs now serve about 1,600 children and adults at a cost of \$9 million, and a recent appropriation for the 1998 fiscal year added another 230 children. If expansion funds are appropriated this spring, a drawing will be held in June for people who have applied by May 31, 1998.

IDHS accepts applications for these programs year-round, but new participants are selected for the programs only when funding is available. When additional appropriations are approved by the General Assembly and signed by the governor, the IDHS conducts random drawings to select potential participants. Selected applicants must then submit income information and be evaluated to verify

their disability.

Physicians and other health care professionals can play an important role by making families and individuals aware of these two programs. By doing so, you may open up a new life for a person with a disability. Brochures and application forms are available from the IDHS

by writing to Family Assistance/Home-Based Support, 405 Stratton Building, Springfield IL 62765-0001 or by calling (800) 843-6154, ext. 3. In the Chicago area, call (312) 814-5981. ■

McManus is the coordinator of the family support programs for IDHS.

Dates for Annual Meeting, resolution deadline set

Mark your 1998 calendar: The ISMS House of Delegates Annual Meeting will be held April 24-26 at the Oak Brook Hills Hotel at 3500 Midwest Road in Oak Brook.

Only delegates and voting members of the House of Delegates may submit resolutions. Resolutions must be received at ISMS headquarters before the close of business on March 24; a March 24 postmark is not sufficient. After that date, resolutions will be considered late and will be reviewed by the Committee on Rules and Order of Business to determine whether the house should con-

sider them.

Resolutions should be addressed to Speaker of the House of Delegates John Schneider, MD, Illinois State Medical Society, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602. The ISMIE Annual Meeting is scheduled for April 22 at the Oak Brook Hills Hotel.

Informational materials and meeting packets for the ISMS Annual Meeting will be mailed to members of the house and county medical societies on March 25. For more information, call (312) 782-1654 or (800) 782-ISMS.



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ISMIE Update

High-risk mothers should be offered glucose screening test

BY LINDA MAE CARLSTONE

Baby Jimmy, now 6 months old, is struggling to crawl, hampered by a left arm that dangles at his side. The boy was diagnosed with Erb's palsy, an injury caused by shoulder dystocia during his delivery that damaged the nerves branching from his spinal cord.

The case in brief: At the time of delivery, the baby's mother was 35 years old and had two other children at home. Her first baby weighed 9 pounds, 8 ounces at birth, but there was no record of how much her second child weighed. The mother was not diabetic, but had several risk factors for gestational diabetes including her age and the fact that she is African-American, a population with a higher-than-average rate of diabetes. Two of the patient's aunts had developed diabetes during their pregnancies, information not recorded in her medical history.

In spite of these risk factors, the patient was not offered a glucose screening for gestational diabetes. Jimmy was born weighing 10 pounds, 2 ounces, about two pounds larger than expected, and his larger size was most likely caused by his mother's gestational diabetes.

The delivery was complicated by shoulder dystocia and Erb's palsy. The mother sued her obstetrician, alleging that the shoulder dystocia was the result of improper prenatal care and improper delivery methods. There was no documentation on the actual delivery, including steps that were or were not taken after the shoulder dystocia was noted.

The points this case makes: The patient should have been offered a glucose screening test to diagnose gestational diabetes, said Melvin Gerbie, MD, a Chicago gynecologist and a member of the ISMIE Ob/Gyn Subcommittee. Some practices offer this test to all patients, he said, but it definitely is war-

ranted if there are high-risk factors for diabetes such as sugar in the mother's urine, a family history of diabetes, a mother older than 30, the apparent large size of the baby, or the mother's history of having a macrosomic infant.

Diagnosing gestational diabetes could have allowed the patient to help prevent the baby from becoming large by controlling her diet and/or using insulin, Dr. Gerbie said. If a physician knows the baby is macrosomic, he or she can arrange for additional help during the delivery. But a macrosomic fetus cannot always be anticipated, Dr. Gerbie pointed out. In addition, shoulder dystocia can be triggered by factors other than a baby's size, such as a small maternal pelvis. Finally,

CASE IN POINT



the problem most often occurs with a normal-sized baby, he added. It must also be noted, that shoulder dystocia usually does not result in Erb's palsy, and most nerve injuries are not permanent, lasting from a few hours to a few months.

"Anyone delivering a baby should be prepared for the management of shoulder dystocia, which was my No. 1 worry in delivering babies," said Dr. Gerbie, who practiced obstetrics for 30 years until becoming chief of gynecology at Northwestern Medical School. "You must have a management plan that includes available adequate

anesthetic so that the patient can tolerate the necessary procedures," he said.

Typical first steps are to make or enlarge an episiotomy and to flex the patient's thighs so that there is more room at the outlet of the pelvis, Dr. Gerbie said. Oblique traction on the head and fundal pressure do not help and are potential causes of maternal and fetal damage. There are several other maneuvers physicians should be trained to perform, Dr. Gerbie said, and the best choice varies depending on individual circumstances.

Good documentation will be a friend in court for any physician battling this type of lawsuit, said Pamela Gellen, partner in the law firm Lewis & Gellen, which specializes in defending physicians and hospitals.

"The plaintiff will argue that the problem would not have occurred if the physician had known the baby was going to be large," Gellen said. Therefore, physicians should document any measurements such as prenatal ultrasound or fundus height that

show they considered the baby's size, she said.

The delivery process should also be well-documented, Gellen said. Details in the record should include who was present at the delivery; what maneuvers were applied, what equipment was used or was not available, she said. An operative report is recommended.

"At a trial, you would want to show that even though you hadn't done the [glucose screening], the outcome would be the same," she said. The documentation should show that you were able to do all the maneuvers you would have done if you had known the mother had gestational diabetes, she said.

A pamphlet, "Exploring Liability Issues in Obstetrics-Gynecology" has been prepared by ISMIE for its policyholders to improve the quality of care and reduce the liability exposure of its insureds. To receive the pamphlet, call (312) 782-2749. ■

"Case in Point" uses hypothetical cases to illustrate risk management maxims.

MALPRACTICE ROUNDUP

Coma patient awarded \$19.28 million

Bleeding heavily due to a placental eruption and suffering from failing kidneys and rising blood pressure, a pregnant woman was treated at a New York hospital without the services of the on-call obstetrician or any other specialists. She later slipped into a coma after delivering a stillborn girl.

In *Abellard vs. New York City Health and Hospitals Corp.*, the attorney for the mother argued that it took eight hours for hospital personnel to note the seriousness of the woman's condition, according to the Dec. 22, 1997, issue of the *National Law Journal*. A superior court jury awarded the woman \$19.28 million after the hospital corporation was sued for negligence in the delivery, as well as negligence in prenatal care.

Even though she was given Pitocin to speed up labor, the attorney said, the baby should have been delivered by cesarean section, not the scheduled vaginal delivery. The hospital's attorney said the patient had an amniotic fluid embolism two hours after delivery that led to respiratory and cardiac arrest.

Angiogram at issue in amputation

A California man who claimed his physician's failure to order an angiogram led to the loss of his leg was awarded \$188,420 by a superior court jury, according to the January issue of *Medical Malpractice Law & Strategy*.

In *Kennedy vs. Zekos*, the patient was treated for right carotid artery stenosis. During the angiogram, the radiologist

could not move the catheter on the right side and believed this was due to occlusion of the right iliac artery. Although the patient complained about pain, cramps and numbness in his right foot, the defendant vascular surgeon said the angiogram showed a brain aneurysm and arterial stenosis that should be treated before the leg symptoms. The surgeon noted the leg symptoms but did not treat them. The leg was later amputated after becoming gangrenous.

The patient's attorney said that a second angiogram would have found the cause of the leg symptoms and prevented the amputation. The surgeon's attorney argued that the aneurysm and stenosis were serious conditions that required immediate attention and that postoperative complications following the treatment required the amputation of the leg.

Radiologist not negligent in detecting cancer

A Baltimore jury found that a radiologist was not negligent for failing to detect signs of breast cancer from a 1992 mammogram of a woman who died two years later of the disease, according to *Lightner vs. Naraval*, cited in the Nov. 17, 1997, issue of the *National Law Journal*.

The defense said the woman's cancer, infiltrating lobular carcinoma, could not be detected by a mammogram. Had it been discovered in 1992, the defense said, it would have been metastasized, making her death inevitable. The plaintiffs sought \$1.8 million to \$3 million.

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Health care goes to Washington

Congressional candidates give medical matters top priority.

BY LINDA MAE CARLSTONE

There's seemingly a great distance between an operating room and the halls of Congress. But Belleville orthopedic surgeon William Price, MD, who has thrown his stethoscope into the ring as a Republican candidate for the U.S. House, finds more similarities than differences when it comes to politics and medicine.

"Physicians in many ways are public servants," Dr. Price said, explaining that the attributes of a good physician — caring, wanting to help, listening — are also the qualities of a good politician.

Dr. Price faces an uphill climb to represent Illinois' 12th District. If he wins the primary, he will likely face incumbent U.S. Rep. Jerry Costello (D-Ill.), of Belleville, the presumptive Democratic nominee, in the general election. "Any challenger has a 7 to 8 percent chance of winning," said Dr. Price. But he isn't just any candidate. As the son

of former U.S. Rep. Melvin Price, a Democrat who represented the area in Congress for 43 years until he died in 1988, Dr. Price has name recognition on his side.

The timing is right for physicians to increase their Washington presence now that so much government regulation impacts health issues, he said. "There are too many CPAs and attorneys making judgments on health care, and a lot of the government's input on health care has been in the wrong direction."

Dr. Price said he is concerned that the corporate takeover of health care is contributing to the crumbling of doctor-patient relationships and the inability of families to choose the best health care. "Physicians have a good understanding of patient needs and are patient advocates. I feel I can do more for medicine in Congress than I could by continuing my private practice."

Several other key congressional races in Illinois fea-

More physicians operating in political arena

When Washington Democrat Rep. Jim McDermott, MD, was first elected to Congress in 1988 there was only one other member of that institution with the letters MD after his name. But the number of physicians in Congress in recent years has skipped "wa-aa-ay higher than when I came," Dr. McDermott said.

Today there are eight physicians in Congress: seven House members and one in the U.S. Senate (see chart). The count could climb higher after the 1998 election. William Price, MD, is a Republican candidate from Illinois' 12th District. He said he is aware of at least two other congressional candidates in his area of orthopedic surgery.

Dr. McDermott attributes the increase to the rapid changes in medicine that are making the profession more and more like big business. "Physicians have become disgruntled and are looking to the political process to change it. We don't all agree, but there's a commonality," said the Chicago-born psychiatrist who completed his residency at University of Illinois Medical School.

Physicians have a lot to offer in the political process, said Rep. Greg Ganske, MD, (R-Iowa) a plastic and reconstructive surgeon. "We tend to be problem-solvers," he said. Two issues in particular, the national debt and welfare, inspired Dr. Ganske's entrance into politics. "I saw 14- and 15-year-old mothers in my office with their babies and there would never be a dad with them. I think the welfare system encourages that the dad not be with them."

Sometimes the political process rubs physicians the wrong way,

Dr. McDermott said. "Physicians are trained to make decisions independently. We don't consult with 435 other doctors," he said, referring to the number of House members. And, there's the fact of majority rule. "Here, you would need at least 218 other doctors who agree with you for treatment of patients."

Dr. Ganske said he has tackled such issues as a ban on gag rules in Medicare and Medicaid plans, consumer protections against managed care abuses and Medicaid funding fairness for rural and low-payment areas. Dr. McDermott said he's anxious to pass a national health insurance plan, but he's quick to acknowledge that some of his fellow congressional doctors are in the House specifically to prevent such a move. "Either way, we think we have something to contribute," Dr. McDermott said.

Some physicians, such as Oklahoma Republican Rep. Tom Coburn, MD, function in Congress as a citizen legislator. "He goes home on weekends to deliver babies," a spokesperson said.

Other physician-legislators set doctoring aside for lawmaking, and some physicians in Congress keep their hands in medicine through volunteer work. Dr. Ganske regularly participates in charity surgical trips overseas to operate on poor children with birth defects. Florida Republican Rep. Dave Weldon, MD, takes part in a county medical society program to provide care for the working poor and indigent.

Dr. Price took leave from his practice last August to concentrate on the campaign. If elected, the Belleville physician said, he would focus on his work as a lawmaker.

Physicians in Congress

If William Price, MD, wins election to the U.S. House of Representatives from Illinois' 12th District, he would join eight other physicians now on Capitol Hill.

	TERM NOW SERVING	AGE	SPECIALTY
Rep. Tom Coburn, MD (R-Okla.)	2	49	Obstetrics
Rep. John Cooksey, MD (R-La.)	1	55	Ophthalmology
Sen. Bill Frist, MD (R-Tenn.)	1	46	Surgeon
Rep. Greg Ganske, MD (R-Iowa)	2	48	Surgeon
Rep. Jim McDermott, MD (D-Wash.)	5	61	Psychiatry
Rep. Ron Paul, MD (R-Texas)	5*	62	Obstetrics
Rep. Vic Snyder, MD (D-Ark.)	1	51	Family practice
Rep. Dave Weldon, MD (R-Fla.)	2	43	Internal medicine

* Dr. Paul served in Congress from 1977 to 1984 and was re-elected in 1996.

Primary candidates for U.S. House



Berg-19th



Dr. Price-12th

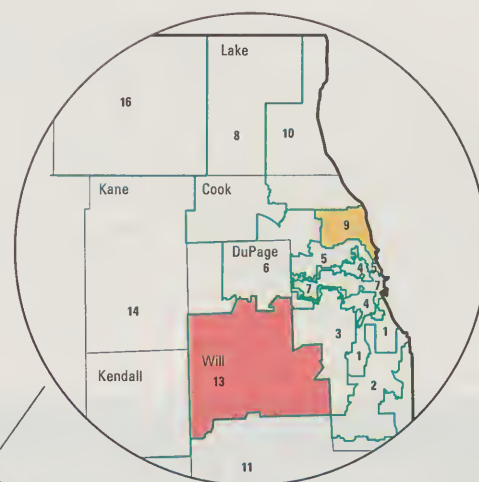
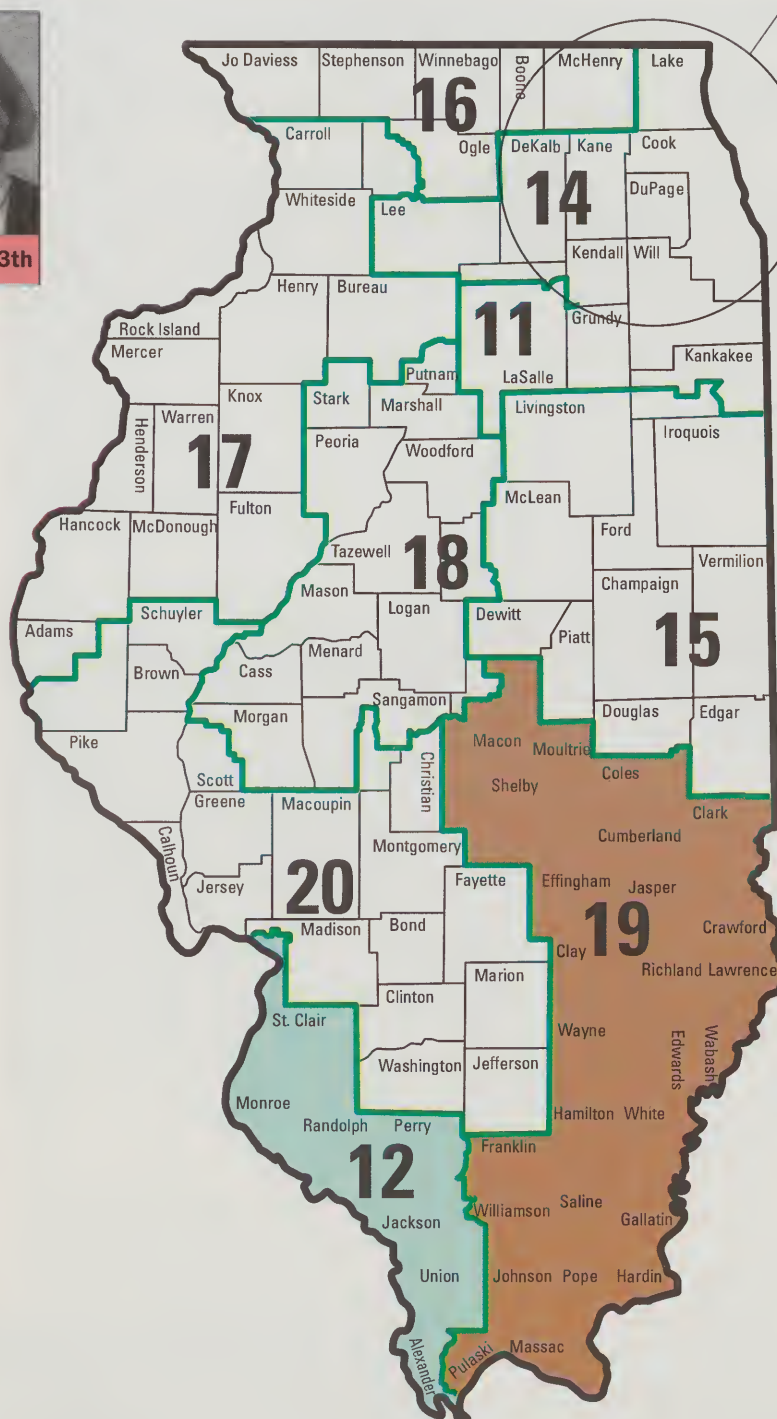


Carroll-9th



Biggert-13th

ILLINOIS CONGRESSIONAL DISTRICTS



ture candidates who have championed efforts to improve health care for patients.

State Rep. Judy Biggert (R-Westmont), a candidate in Illinois' 13th Congressional District, has a track record in support of patient rights during her six years in the state Legislature. A Biggert-sponsored law guarantees women and their newborn babies proper hospital recovery time. The law requires insurance companies to provide a minimum coverage of 48 hours inpatient care following a normal birth and 96 hours after a cesarean section.

Biggert, who is in a six-way Republican primary battle, also sponsored legislation that requires managed care plans to provide insurance coverage allow-

ing women to stay in the hospital for a minimum of 48 to 96 hours following mastectomies.

Health care and government budgets are tightly linked, said state Sen. Howard Carroll (D-Chicago), a 9th Congressional District candidate for the seat being vacated by retiring U.S. Rep. Sidney Yates.

A state senator since 1973, Carroll said he honed an expertise in health care during his 16 years on the Senate Appropriations Committee. He helped create the Comprehensive Health Insurance Plan, the state program to provide medical insurance for people who have been denied coverage due to pre-existing medical conditions. Carroll

(Continued on page 10)

Health care

(Continued from page 9)

said his appropriations experience gives him the best shot at the coveted appropriations committee, which oversees the federal budget. Illinois will lose a seat on the committee when Yates steps down.

One of Carroll's Democratic primary opponents is state Rep. Janice Schakowsky (D-Evanston), who sponsored a bill to place prejudgment interest on malpractice liability and other civil lawsuits. The measure would, in effect, have substantially increased a malprac-

tice lawsuit judgment. She also sponsored a physician-profiling bill. Carroll also faces J.B. Pritzker of Evanston and Pat Boyle and Joseph Slovenic, both of Chicago, in the Democratic primary.

Streamlining the paperwork burden physicians face in Medicare reimbursement is a cause that 19th District Congressional GOP primary candidate Jerry Berg said he is ready to tackle. "HCFA rules on hospital and physician reimbursement are turning into a witch hunt for fraud and abuse," said Berg, who has met with physicians throughout the district who have stressed the need for Medicare reform.



Fitzgerald



Didrickson

"The hardship weighs particularly heavy on individual practitioners or on members of very small groups. In effect, they are small-business people. I would challenge anyone to find a small

business that has as many administrative headaches as a physician's office."

Berg said he has gained an insider's understanding of medical finances working for the last five years with rural hospitals to put together tax-exempt bond issues to finance major hospital construction. Berg, of Oreana, faces Brent Winters, of Charleston, and James Eatherly, of Galatia, in the GOP primary, for the seat being vacated by Democratic gubernatorial candidate Glenn Poshard. In the 19th District Democratic primary, state Rep. David Phelps of Harrisburg faces Jerry Eckl of Newton.

Berg said he would work for tort reform that would place reasonable limits on pain and suffering liability for malpractice and product liability judgments. "Our legal system is out of control. If someone spills a cup of coffee, they've won the lottery."

Physicians have a tough choice in the Republican primary for U.S. Senate where they must decide between Illinois Comptroller Loleta Didrickson, of Chicago, and state Sen. Peter Fitzgerald (R-Palatine). Each has consistently supported physician issues, including tort reform, during their tenures in the Illinois Legislature. Fitzgerald was elected to the Senate in 1992. Didrickson served in the Illinois House from 1983 through 1990 and was elected comptroller in 1994. The winner will challenge incumbent U.S. Sen. Carol Moseley-Braun in the November general election for the chance to be the first Republican U.S. senator from Illinois in 14 years. ■

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Illinois task force studies food regulation system

[SPRINGFIELD] It's no secret that the public is increasingly concerned about food safety. With safety as its goal, a 26-member Illinois Food Safety Task Force is reviewing the state's food regulation system.

"This task force will fully review Illinois' food regulation system and will weigh recommendations to ensure even greater efficiency and effectiveness," said Gov. Jim Edgar in announcing the task force. Consumers, dairy farmers, academicians and retailers will constitute the task force, with Illinois Department of Public Health Director John Lumpkin, MD, and Illinois Department of Agriculture Director Becky Doyle serving as chairmen.

"With new and more virulent pathogens threatening our foods, we must do whatever is necessary to make the food supply safer than ever before," Dr. Lumpkin said. "No Illinoisan should have to think twice about the milk they drink, the eggs they use or the hamburger they eat."

The task force will examine the effectiveness of the current food regulatory system in the areas of production, processing, sales and service. "Ensuring a safe food supply does more than protect human health, it builds confidence in Illinois foods and agriculture products," Doyle said. "Ultimately, that confidence could translate into increased value and demand for Illinois meat, poultry, grain, produce and processed foods." ■

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IDPR defines how

(Continued from page 1)

have 150 CME hours during a three-year period, including 60 hours of Category 1 and 90 hours of Category 1 or Category 2, according to the AMA.

Without the PRA certificate, the IDPR rule gives physicians the option to earn all formal hours if they so choose, but limits what they can earn in informal hours, Courtney said. The rule uses "formal" and "informal" to describe the types of hours, which are equivalent to Category 1 and Category 2, respectively, Courtney said. In one year, physicians are required to earn a minimum of 20 formal CME hours, and they are limited to earning a maximum of 30 hours of informal CME.

According to the rule, formal hours include those earned from programs conducted or endorsed by hospitals, specialty societies, facilities or other organizations approved to offer CME credit. Informal hours include consultation with peers or experts, preparation of educational exhibits and the use of electronic databases for patient care.

On renewal applications, physicians will be required to show they've completed the necessary CME, Courtney said, but they won't have to submit supporting documentation with the application. Instead, once all licenses have been renewed, IDPR will choose a percentage of the applications to audit. Only those applicants will have to provide follow-up documentation of the 50-hour requirement.

Certificates given for completing

CME programs, like those offered by hospitals, can be used as proof of formal hours. For informal hours, Courtney said physicians could keep track of the dates for group meetings or discussions as proof they have done the work.

The audits could take from six months to a year to complete, Courtney said, and physicians should keep their documentation at least through the next renewal period.

Physicians who fail to provide appropriate proof face the standard IDPR disciplinary process, Courtney said. The Medical Disciplinary Board will make the final decision on any penalties, which can include a reprimand or license suspension.

Dr. Cummings said she's often asked why retired physicians must earn the 50 hours of CME. "There is no way for the licensing board or anyone else to know that [retirees] are not still actively practicing medicine," she explained.

Once the rule is final, IDPR plans to send a mailing to physicians outlining what they must do to meet the new requirement. A 45-day comment period began when the rule was published in the Illinois Register. Once that concludes, IDPR will review any remarks it receives for possible inclusion into the rule. Courtney said, however, that the bulk of the regulation is expected to remain intact. The rule will most likely become official this summer.

Physicians who have questions about the CME requirement may contact ISMS' Education and Licensure Division at (800) 782-4767 or (312) 782-1654, ext. 1165. ■

APRN

(Continued from page 1)

quite a bit and cited the Society's recent support of giving nurses delegated prescriptive authority for Schedule III through V drugs.

ISMS plans to continue negotiations, said ISMS President Jane Jackman, MD. "We really appreciate that APRNs are a growing part of the health care team," she said. "But, if you are going to put in legislation what an APRN can and cannot do, we want to make sure that there aren't any abuses."

The ISMS bill requires all four types of APRNs – nurse anesthetists, clinical nurse specialists, nurse midwives and nurse practitioners – to have a written collaborative agreement with a physician. INA's bill also requires a written collaborative agreement for three types of APRNs, but exempts nurse anesthetists from the requirement.

The INA version of a written collaborative agreement doesn't limit the scope of practice for midwives, nurse practitioners or clinical nurse specialists to the scope of practice of the collaborating physician, Dr. Jackman said.

"The [INA] bill pretty much describes the scope of practice as being independent practice for nurses, especially nurse anesthetists. We don't think that is going to be safer for public health," Dr. Jackman said. "Doctors and APRNs are different from each other, and it's not just our training. It's our background and our patient focus."

ISMS and INA also disagree on the

need for ratios. To ensure a meaningful collaboration, ISMS supports a ratio that allows one physician to have collaborative agreements with two APRNs. An exception would allow one physician to have collaborative agreements with four nurse anesthetists. The ratio would restrict the number of agreements a physician can have; it doesn't limit the number of agreements an APRN can have.

The 2-1 ratio mirrors one already in place for physician assistants in Illinois, and the 4-1 nurse anesthetist ratio is consistent with rules set by the U.S. Health Care Financing Administration. In December, however, HCFA proposed a new rule that essentially allows nurse anesthetists to practice independently. The proposal would not pre-empt state laws and standards set for nurse anesthetists. ISMS has submitted comments to HCFA detailing its concerns with the proposed rules.

Unlike ISMS, INA doesn't support ratios. "We are afraid that, with the emphasis on the bottom line in health care these days, the potential for abuse is enormous," Dr. Jackman explained. Without ratios, for example, a physician who also happens to be an entrepreneurial medical director could hire multiple APRNs and sign agreements with all of them. "There would be no meaningful collaboration with the APRNs," Dr. Jackman said.

A lot of misinformation exists about the Society's position on the APRN issue, Dr. Jackman said. Call (800) 782-4767 for more information about ISMS' stance on this issue or for a copy of the Society's position paper. ■

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Stark sequel expands referral bans

REVISION: HCFA lays down more reasons not to refer.

BY LINDA MAE CARLSTONE

[WASHINGTON] Government restrictions on Medicare referrals have entered a new era called Stark II, a federal law broadening the limitations on physician referrals.

The regulation can be considered a sequel to Stark I, the 1992 law written by Rep. Pete Stark (D-Calif.) and intended to clamp down on fraudulent Medicare and Medicaid charges by providers trying to reap financial gain from improper referrals. The earlier version bars physicians from referring Medicare and Medicaid patients for laboratory tests to facilities in which those physicians have a financial stake.

Stark II is like a full-length feature to its shorter predecessor, according to a spokesperson for the U.S. Health Care Financing Administration, which administers Medicare and Medicaid. "It's a more mature law," she said. "The first one wasn't broad enough."

Physicians mindful of the ins and outs of their financial relationships now have much more to contemplate. The proposed regulations are heaped with 11 designated health services where referrals are forbidden if the physician has financial interest. In Stark I, a clinical laboratory was the only service entity barred from referrals. Prohibited categories now include physical therapy; occupational therapy; physical laboratory services; radiology or other diagnostic services; radiation therapy services; durable medical equipment; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics and prosthetic devices; home health services; inpatient and outpatient hospital services; and outpatient prescription drugs. As in Stark I, the financial interest can arise from either ownership or investment or from a contractor compensation arrangement or other financial relationships.

The Stark II laws were passed in 1992 and 1993 and were recently published by HCFA in the Jan. 9 Federal Register as "Medicare and Medicaid Programs: Physicians' Referrals to Health Care Entities with Which They Have Financial Relationships." HCFA is accepting through March 10 comments on the proposal that it will consider before issuing a final ruling. The process could take more than a year, depending on the complexity of the comments.

Even though the rule is not yet final, the Stark II legislation went into effect Jan. 1, 1995. Pieces of the regulation that are "clear on their face" will be enforced retroactively to that date, the HCFA spokesperson said. It is clear, for example, that a spouse counts as a family member, so that category would be already prohibited from a referral. Other definitions that involve more discretion will not go into effect until 30 days after the final rule is published.

John Schneider, MD, ISMS Third Party Payment Processes Committee Chairman, said that physicians will need to review the regulations carefully. Even relationships that appear reasonable on the surface may not be acceptable to HCFA, so physicians may need to consult an attorney for advice on Stark II, he said.

Dr. Schneider said physicians will

have the most trouble in deciphering the legality of referrals to clinical lab services. A typical situation that could present a conflict is when several groups in the same building share a lab. Referral is appropriate if the lab is in a physician's suite but not if it is in a separate part of the building because direct supervision is required, Dr. Schneider said.

Physicians can call HCFA with questions, but should be aware that the agency's oral opinion is not reliable in court, according to an ISMS analyst. A formal opinion issued in writing by HCFA is available for a fee. (See story at right.) Questions regarding the ruling can be directed to HCFA at (410) 786-3000.

There are many exceptions to the referral ban, however they are tied to a variety of qualifying conditions and are only valid if specific circumstances are met, the ISMS analyst said. Exceptions are allowed for services performed by a physician in the same group practice as the referring physician. A second exception is for in-office ancillary services performed by the referring physician or another physician in the same group. There are also exceptions to the ownership terms, such as if the financial involvement is in a publicly traded stock or mutual fund of a health care provider.

A rural provider is exempt from the rule if the patient is also located in a rural area. An exception exists for an ownership interest in a hospital if the referring physician has staff privileges at the hospital.

Stark II violators could be denied the payment of their Medicare or Medicaid claim and be forced to refund money received through a copayment. Violators who knew or should have known the claim was illegal can be fined up to \$15,000 and can be excluded from the Medicare program if caught in a scheme to circumvent Stark II. ■

Opinions can help avert fraud, abuse

The question of what is allowed under Stark II when referring Medicare and Medicaid patients to specific health care entities is now easier to sort out with the availability of advisory opinions from the Health Care Financing Administration.

Physicians can request a binding formal written opinion on whether patient referrals would violate the Stark II law, which bars physicians from making referrals in which they may have financial interest.

The opinions were required under the Balanced Budget Act of 1997 after an intensive push by the American Medical Association. The chance to get questions answered in writing significantly raises the comfort level for physicians who have legitimate operations, an AMA spokesperson said. "Up until now you could have a verbal conversation, but there was nothing in writing to rely on from the government if you got into trouble later," he said.

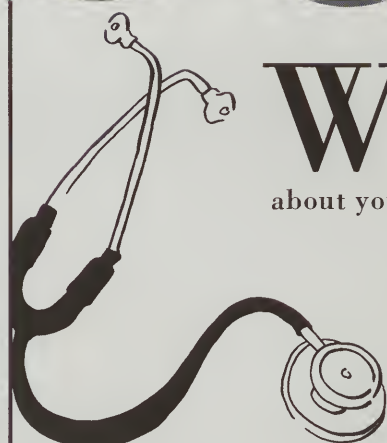
Under the terms of the regulation,

requests must involve an existing arrangement or one the requesting physician plans to enter. The requests cannot be based on hypothetical situations. The opinion applies only to the requesting physician and not to any individual or entity that does not join in the request.

HCFA has 60 days to issue its opinion, but the deadline can be extended if time is needed to collect more information. Requesting physicians must pay HCFA a nonrefundable \$250 fee for the opinion and agree to cover all additional costs incurred in responding to the request.

Simple questions can be answered over the telephone, according to an HCFA spokesperson. The oral opinions are not meant to be legally binding, according to an ISMS analyst. The HCFA spokesperson said she often receives queries that do not require a formal advisory opinion. HCFA has received one request for such an opinion since they became available, she said.

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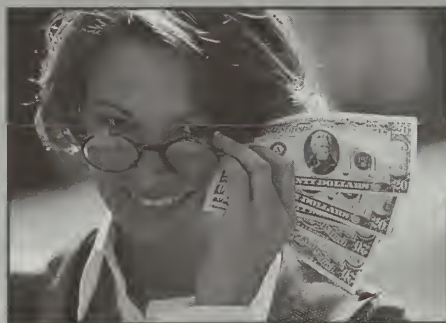


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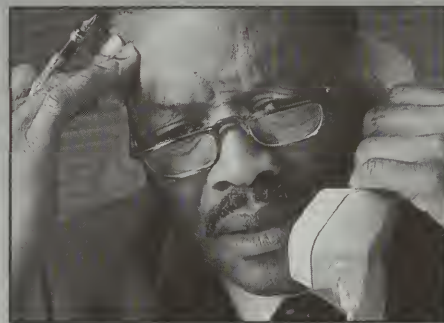


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New managed care

(Continued from page 1)

concessions that address criticism that the measure will be costly to implement, Schoenberg said. H.B. 3530 and S.B. 1666 requires managed care plans to establish a health care delivery policy advisory board made up of physicians, providers and enrollees. The board replaces a requirement in the 1997 MCPRA for a medical staff comprised of all physicians who provide health care services to plan enrollees. Medical staff consent would have been required in such areas as developing and implement-

ing of quality assurance procedures and medical policy. Under the House and Senate proposals, the advisory board would work with the managed care plan to establish the plan's health care delivery policy. However, the plan's governing body would have the final decision.

Specific measures in the bills outline patient rights to receive quality care, to be informed about that care, to have privacy and confidentiality and to purchase additional health care services with their own money, Dr. Jackman said. Managed care plans would be required by the bills to provide prospective enrollees with written

information on their terms and conditions.

A point-of-service option allows patients freedom of choice of physicians, if they will pay any extra cost of that choice. "Most managed care companies still operate on a gatekeeper principle where you use a primary care provider and get a referral if necessary," she said. "This blanket, one-size-fits-all approach doesn't suit everyone. For example, this approach does not work for many cancer

patients who will need access to an oncologist the rest of their lives."

Provider rights are also protected in the bills. The bills mandate that providers receive a due-process appeal for adverse participation decisions. "Physicians deserve an explanation as to why they are being dropped from a plan," Dr. Jackman said. The bills require providers to be given notice of an action, an opportunity for discussion and an opportunity to enter into a corrective plan except where patient health is in jeopardy.

"This is not to say that managed care companies cannot drop a physician," Dr. Jackman said. "But physicians should not have to live in fear of deselection just because they are being patient advocates."

The legislation also addresses concerns about gag rules and gag practices that forbid physicians from revealing certain kinds of information to their patients about treatment options. The bills state that no managed care plan may prohibit or discourage health care providers from discussing with patients any alternative health care services and providers.

A separate managed care patient rights bill, H. B. 626, passed the House last year and remains mired in the Senate, which has been conducting hearings on the issue since last spring. Schoenberg predicted that the several bills introduced on the issue will be reconciled and emerge as a comprehensive bill. "I don't know how we can afford not to [pass it], given the growing segment of the population we represent that falls under managed care plans." ■



Rep.
Schoenberg

information on their terms and conditions. A point-of-service option allows patients freedom of choice of physicians, if they will pay any extra cost of that choice. "Most managed care companies still operate on a gatekeeper principle where you use a primary care provider and get a referral if necessary," she said. "This blanket, one-size-fits-all approach doesn't suit everyone. For example, this approach does not work for many cancer

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MCPRA sponsors

The Managed Care Patient Rights Act was recently introduced into the Illinois General Assembly in identical bills, H.B. 3530 and S.B. 1666.

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CAUSE RISK MANAGEMENT CONCERNS (PAGE 7)



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Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • MARCH 20 1998

IDPH proposes name reporting of HIV patients

PAGE 2

HCFA sidelines physicians, weakens their role in hospitals

MEDICARE: Rule emphasizes the bottom line over quality of care. BY JANE ZENTMYER

[WASHINGTON] A pending rule from the U.S. Health Care Financing Administration outlining the conditions hospitals must fulfill in order to participate in Medicare and Medicaid relegates physicians to the sidelines in hospitals. Concerned

physicians said that the rule could threaten the quality of patient care in a marketplace that emphasizes a hospital's bottom line.

"The proposed rule substantially weakens the role of physicians in hospitals," wrote M. LeRoy Sprang, chairman of the ISMS Board of Trustees, in a letter sent to HCFA in February. "Physicians are the only individuals in hospitals who have the expertise and training to adequately oversee and coordinate patient care, to ensure patients receive quality care and to ensure continuous quality improvement in health care delivery processes and outcomes."

Physicians across the country have harshly criticized HCFA's rule, released on Dec. 19. HCFA had originally planned to accept comments through part of February. The deadline has since been extended to April 20.

The rule consolidated and streamlined the existing regulations, said Nancy-Ann Min DeParle, HCFA's administrator. "Our new system focuses on the actual care hospitals provide as the way to judge and improve quality, rather than bureaucratic rules and enforcement that focused on whether providers had required structures and procedures in place."

But, in its attempt to rewrite a hospital's structures and procedures, HCFA weakened the roles of medical staffs.

"The medical staff is an important aspect of a hospital operation," said Theodore Kanellakes, MD, chairman of the ISMS Organized Medical Staff Section. "They are given the sole responsibility to determine and maintain quality in the implementation of care. And nothing should weaken the medical staff and its

(Continued on page 11)



Ron Ackerman

ELIZABETH STROW, MD, (right) voices her views about APRN licensing before the Illinois House's Registration and Regulation Committee as Steven Hall, MD, (far left) and ISMS Legal Counsel Robert Kane listen.

Illinois House begins hearings on APRN bills

ADVOCACY: Physicians explain their position on APRN licensure. BY JANE ZENTMYER

[SPRINGFIELD] The ongoing struggle to appropriately license Illinois' advanced practice registered nurses is once again on the General Assembly's agenda. The issue's legislative debate began on Feb. 25 when physicians and nurses argued their respective positions before the Illinois House's Registration and Regulation Committee.

"APRNs across the country are assuming responsibilities that have previously been reserved for physicians," ISMS President Jane Jackman, MD, told committee members. "The time has come to recognize their increasingly important role, and the new ways physicians and nurses are working together, with a licensing law that expands patient access to cost-effective health care - but without compromising quality."

Dr. Jackman said the Society supports APRN licensure as

described in H.B. 3520, which is identical to S.B. 1585, and strongly opposes APRN licensure as proposed by the Illinois Nurses Association. The ISMS-endorsed bill incorporates policies and positions adopted by the ISMS House of Delegates and the ISMS Board of Trustees. It also reflects almost two years of work by an ISMS ad hoc subcommittee on advanced practice nurses, which had extensive discussions with nursing groups and medical specialty societies.

"There is no disagreement on APRN licensure in Illinois per se, but only disagreement as to its best form," said Sue Clark, INA's director of government relations. INA's vision of APRN licensure is contained within H.B. 2921, identical to S.B. 1253.

ISMS and INA disagree on a key aspect of APRN licensure -

(Continued on page 12)

Sunny economy shines on public health funding

BUDGET: Medicaid remains on sound footing. BY LINDA MAE CARLSTONE

[SPRINGFIELD] There's a smile on Gov. Jim Edgar's face as Illinois basks in its sunny economic climate. The governor's joy was expressed in real numbers last month as he laid out his budget proposal for the coming fiscal year. The proposed budget earmarks \$6.12 billion for the Illinois Department of Public Aid, a 6.8 percent increase over the current year's \$5.7 billion appropriation.

"Today, I am proud to present a budget that is balanced," Edgar stated in the fiscal 1999 budget address presented Feb. 18 to the Illinois General Assembly. "It reflects, embraces and embodies the fiscal discipline we demanded and won."

Illinois Department of Public Aid General Revenue Fund FY 1998 estimated spending vs. FY 1999 proposed			
	FY 1998 est. spending (in thousands)	FY 1999 proposed (in thousands)	Percent increase
Physicians	\$ 325,710	\$ 333,809	2.5
Prescription drugs	563,941	647,323	14.8
Home health care	61,739	76,467	23.9
Hospital	1,406,668	1,494,844	6.3
Transportation	52,597	62,093	18.1
Source: IDPA			

The governor's proposal must be approved by the legislature in its current session, scheduled to close May 22. Fiscal 1999 begins July 1.

The budget maintains Medicaid's sound financial footing.

Funding for Medicaid accounts for the bulk of the IDPA's proposed health care spending, \$5.8 billion or 95 percent. Edgar indicated that medical providers will continue to be

(Continued on page 14)



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IDPH proposes HIV name-reporting process

[SPRINGFIELD] In February, the Illinois Department of Public Health proposed a rule that would require physicians to report names of patients testing positive for HIV, a position taken by the ISMS House of Delegates since 1994. At least 31 other states, including Indiana, Missouri and Wisconsin, now mandate name reporting.

"We've carefully studied the issue of name reporting for two years and believe the time has come to treat HIV

like other sexually transmitted diseases," said IDPH Director John Lumpkin, MD. "For years it's been argued this disease should somehow be treated differently because of the social stigma attached to it. Disease prevention, however, is a medical problem that needs to be treated through proven public health solutions."

The earliest the rule could become effective in Illinois is late spring or early summer.

A 45-day comment period began with the rule's Feb. 27 publication in the Illinois Register. IDPH officials will listen to the proposal's supporters and opponents at two hearings. The first hearing will be March 30 in Springfield and the second April 27 in Chicago.

IDPH will submit comments it receives and its own responses to the Legislature's Joint Committee on Administrative Rules, which must sign off on the proposal before it can take effect. The committee will make its decision following a second 45-day comment period, said IDPH spokesperson Tom Schafer, who also noted that the Centers for Disease Control and Prevention has urged Illinois to implement this procedure.

In 1994, the ISMS House of Delegates approved a position supporting mandatory reporting of HIV-infected individuals to the IDPH.

IDPH currently requires name reporting for at least 60 infectious diseases, including AIDS, tuberculosis, syphilis and gonorrhea. The proposed process for reporting HIV, however, will differ from procedures now used for other infectious diseases, Schafer said.

The rule would require physicians to report names of those testing positive for HIV to a local public health department, where a number — also known as a unique identifier — would be assigned to each individual. A patient's demographics would be provided to IDPH through this unique identifier by the local public health

department, allowing IDPH to track trends in the spread of HIV without receiving a person's name.

Schafer said unique identifiers would help IDPH eliminate duplicate reporting. The name-reporting process would also encourage local health departments to provide counseling and partner notification services to HIV-positive individuals. This would be a particular benefit to those tested in private settings, where, Dr. Lumpkin indicated, a CDC study found only 25 percent of people received counseling with their results.

Although critics argue name reporting will deter people from being tested, IDPH said a recent CDC study found only 1.4 percent of HIV-positive individuals in nine states delayed testing because of a reporting system. Also, according to Dr. Lumpkin, since 1981, when IDPH began collecting names of individuals with AIDS, 20,386 have been recorded without a single breach in the reporting process.

However, to reassure those still concerned about confidentiality, Dr. Lumpkin said IDPH plans to continue funding its 64 Illinois anonymous-testing sites.

Clinton honors physician, calls him 'local hero'

[URBANA] President Bill Clinton honored Curtis Krock, MD, an internist with Carle Clinic in Urbana, as one of 15 central Illinois "local heroes" during a Jan. 28 rally at the University of Illinois.

Dr. Krock and the other honorees met Clinton and Vice President Al Gore at University of Illinois' Willard Airport and accompanied them in a motorcade to Assembly Hall on the U of I campus where the president delivered a well-received speech recognizing the heroes.

The physician said he congratulated Clinton on his recent State of the Union address and mentioned that he, too, had graduated from high school in Arkansas, a discovery that seemed to delight the president.

Dr. Krock, who has been with Carle Clinic for 25 years, was honored as a result of efforts by the daughter of a patient he'd treated and to whom he'd made house calls. The patient's daughter contacted the White House to get recognition for Dr. Krock's efforts.



Dr. Krock

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Society's legislative wish list put before the General Assembly

ROUNDUP: Bills target physicians participating in executions, smokers in restaurants and alcohol ads on billboards. BY LINDA MAE CARLSTONE

[SPRINGFIELD] If all bills introduced into the Illinois Legislature become law, by year's end human cloning will be illegal, restaurants will be smoke-free and alcohol ads will be taboo along some state highways. But bills do not automatically become laws merely by being put before the Illinois General Assembly. Proposed legislation is just at the starting gate for 1998, where the deadline for filing bills to be considered this year was Feb. 20. Passage is not assured because this is an appropriations session dedicated to budget items and measures deemed emergencies, as well as an election year, said Nestor Ramirez, MD, chairman of the ISMS Governmental Affairs Council. He noted that ISMS has been the driving force behind several bills introduced this spring, including:



discharged from the hospital. The bill would substitute cardiopulmonary resuscitation, in accordance with the American Heart Association guidelines, for the current reference to performing the Heimlich Maneuver on an infant. H.B. 3435 is sponsored by Rep. Ralph Capparelli (D-Chicago).

PARTICIPATION IN EXECUTIONS

The Society continues legislative efforts to eliminate physicians from the execution process. Since a physician's role is to heal and do no harm, it is ISMS policy that physicians should not participate in implementing the death penalty. Two ISMS-endorsed bills, one each in the House and Senate, state that the Illinois Department of Corrections shall not require, request or allow licensed health care providers to participate in executions.

The bills also attempt to undo a 1995 law exempting physicians from disciplinary action if they take part in executions. H.B. 3434 is co-sponsored by Rep. Tom Ryder (R-Jerseyville) and House majority leader Rep. Barbara

Flynn Currie (D-Chicago). The identical S.B. 1489 is sponsored by Sen. Arthur Berman (D-Chicago).

LIQUOR BILLBOARD BAN

Billboard liquor ads along some Illinois highways would be erased from the landscape by a bill to prohibit highway road signs that advertise alcoholic beverages. H.B. 3433, sponsored by Rep. Monique Davis (D-Chicago), reflects a long-standing House of Delegates policy to take an active role in reducing drunken driving. In 1996, the HOD specifically directed the Society to encourage the development of legislation to prevent alcohol advertising on billboards.

RESTAURANT SMOKING BAN

The question "Would you prefer the smoking or nonsmoking section?" would become moot in Illinois restaurants under a bill to snuff the use of tobacco in eating establishments. The bill, H.B. 2849, sponsored by Rep. Carolyn Krause (R-Mount Prospect), mirrors an HOD resolution to ban smoking in all Illinois restaurants.

Besides these ISMS-driven bills, other health care proposals introduced include:

NEEDLE, SYRINGE EXCHANGE

S.B. 1263, sponsored by Sen. Donald Trotter (D-Chicago), would establish a needle and syringe exchange program in the five counties with the highest number of AIDS cases among intravenous drug users. ISMS policy favors the concept of needle exchange programs as a potentially

useful tool to curb the spread of HIV, when combined with educational and preventive efforts, and done in concert with local law enforcement agencies. In 1995, the HOD urged adoption of legislation allowing responsible community groups to establish needle exchange programs. In response to proposals on needle programs introduced into the General Assembly in 1997, the ISMS Ad Hoc Committee on Needle Access was formed to study needle program options. Components being studied include distribution sources and disposal methods.

BAN ON HUMAN CLONING

Two separate Senate bills would prevent human cloning. S.B. 1230, introduced by the late Sen. Penny Severns (D-Mount Zion), would also prohibit the use of public funds or property to clone humans. Anti-cloning S.B. 1242, sponsored by Sen. Patrick O'Malley (R-Alsip), also prohibits the sale or purchase of a zygote, embryo or fetus for human cloning.

CRIMINAL BACKGROUND CHECKS

S.B. 1430, sponsored by Sen. Kathleen Parker (R-Northfield), requires criminal background checks for a person hired as emergency medical technician, First Responder, trauma nurse specialist or pre-hospital registered nurse. Under the bill, anyone convicted of certain crimes may not be hired for those positions. Among the specified offenses are homicide, kidnapping, sex offenses, assault, battery, financial crimes against the elderly, and various drug and alcohol violations. ■

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EDITORIAL

When your car is trapped in water

Today marks the first day of spring, and, for too many Illinoisans, this season is closely associated with flooded basements, swamped fields and overflowing sewer drains. It's also the season for one of the most deadly combinations: high water and roadways. According to the National Highway Traffic Safety Administration, some 313 Americans died after being trapped inside a submerged vehicle in 1994, the latest data available. Other data, cited by the International College of Surgeons, suggest that about 60 percent of all passengers and drivers who become submerged do not escape.

ISMS has long supported improved safety features in a variety of settings, so it's no surprise that the Society has asked automakers to help vehicle occupants safely escape water entrapment. Specifically, ISMS and the American Medical Association want automakers to build into every vehicle at least one mechanical window control that can override power windows. The two organizations have also asked the National Safety Council and the American Automobile Association to support this idea. It makes sense: When a car hits deep water, electric windows can short out – and remain closed – as the car sinks, trapping its occupants. Mechanical window controls would give those trapped one more chance to escape.

When a car skids from the road and

into a swollen creek or river – or hits deep water beneath viaducts or in low-lying areas – drivers and passengers have only seconds to react. The National Safety Council says it's best to leave a vehicle and seek shelter if the occupants find themselves facing submergence. The occupants should immediately exit once the car or truck lands in the water. If the vehicle has power door locks, the occupants must immediately unlock the doors before the system short-circuits, according to Shell Oil, which is now waging a major safety campaign about water entrapment.

It's also important to keep the seat belts in place until the car goes into the water, Shell's promotional materials urge, because the car's impact can be dangerous. Once the vehicle stalls, the occupants must try to open a window and swim to safety. If they can't get through the window, the occupants should try to break it or open the door, according to the National Safety Council. While the pressure of the water may hold the door closed at first, the pressure will equalize as the water rises and the door should open. But this can take only seconds, and a cool head can make the difference.

The ISMS House of Delegates' request for at least one nonelectric window control in all vehicles is practical and sensible. Now, it's up to the automakers to take the next step for the public safety.

PRESIDENT'S LETTER

The continuing saga of lawsuit reform

Jane L. Jackman, MD



We might take inspiration from John Paul Jones, who replied, "I have not yet begun to fight."

December 18, 1997, was a very dark day for the medical profession in Illinois. When our Supreme Court overturned all of the 1995 tort reforms in that one day, our state took one giant step backward for patients. Inevitably, health care will become more expensive for all, and access for many, especially in the underserved areas of Illinois, will be more difficult.

We have now had three months to reflect on what this means for us and to formulate a remedy. Of course, it is heartbreaking to have the cap on noneconomic damages slip through our fingers so quickly after 20 years of hard work. We must continue the battle, however long it may take, because these reforms are so vitally important to all doctors. We might take inspiration from the words of the American revolutionary sea captain John Paul Jones, who, when asked in 1779 if he was ready to surrender to the British frigate Serapis replied, "I have not yet begun to fight." The current fight, though, has no small, quick cure and will necessitate long-range planning.

The core of the 1997 Supreme Court decision was that a \$500,000 cap on noneconomic damages was "special legislation and violated the constitutional guarantee of separation of powers between the branches of government." Based on the court's majority opinion that the cap was unconstitutional and therefore invalid, all of the other 1995 tort reform legislation was struck down.

Justice Benjamin Miller was the one dissenting vote in the court on every item except for the Petrillo doctrine, which dealt with access to medical records. His conclusion sums up very well our perspective when he said, "Today's decision represents a substantial departure from our precedent on the respective roles of the legislative and judicial branches in shaping the law of this state. Stripped to its essence, the majority's mode of analysis simply constitutes an attempt to overrule, by judicial fiat, the considered

judgment of the Legislature."

It is said that every cloud has a silver lining, and one cheering event has happened in the last three months. The Illinois Civil Justice League, which won tort reform in the legislature in 1995, has been reinvigorated. ISMS and ISMIE are members of the ICJL.

The ICJL is sending its own questionnaires to sitting judges running for retention and to candidates seeking election to the bench. The league has been accused by the president of the Illinois Trial Lawyers Association of a "blatant attempt to intimidate the court and to belittle it in the eyes of the public." However, the ICJL President Edward Murnane replied that "we are interested in determining how the courts are functioning, how judges are fulfilling their duties." Certainly everyone will be well served by the election of knowledgeable, impartial and fair-minded judges who realize that their actual role is that of jurist, not that of lawmaker.

We have to keep malpractice insurance affordable and work toward the creation of a fairer civil justice system in Illinois. We shouldn't feel powerless against the perceived undue influence of the plaintiffs' bar. We can fight back! Talk to your legislators about what happened. How do they feel about the Supreme Court usurping their authority to decide public policy? Tell them how this injustice will affect your practice, the care available to your patients and medical costs. Talk to your patients about how it will affect their access to affordable care. Get involved in electing not only legislators who support our position, but also good judges. Give to the Illinois State Medical Society Political Action Committee generously. Consider the Supreme Court's decision as only a temporary setback. With committed, involved members and a dedicated Medical Society, we will win back the 1995 tort reforms over time.

GUEST EDITORIAL

Doctor's white coat fits all: Jekyll, Kildare, medicine man

By Abigail Zuger

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As totems go, a doctor's white coat is a real bargain. For \$22.95, anyone can pick up a very nice wrinkle-resistant cotton-poly version, with three pockets and a dignified belt in the back. For just a little extra, you can have your name embroidered in tremulous red script over the breast.

But the question is, does anyone really want one anymore? Unlike surgical scrubs, which have enjoyed a certain fashion cachet for years now, the white coat remains exactly what it was almost a century ago, a stiff symbol of the entire ethos of Western scientific medicine, from Jekyll and Frankenstein right on through Welby and Kildare. It can connote every point along the spectrum: cold and calculating, warm and caring, utterly dedicated, deeply demented.

And doctors cope differently with all that symbolism. Some would no sooner see a patient without a coat on than they would work stark naked. Others shed the coat the moment they can.

In the last five years, many medical schools have begun to stage a "white coat ceremony" at the beginning of the school year, in which first-year students put on their new white jackets and listen to the same kind of inspirational talk they will hear again at their graduation four years later.

Still, it is the dark side of the white coat that permeates medical textbooks: People who are made so anxious by the doctor that their blood pressure soars are said to have "white-coat hypertension" and are at risk of being prescribed unnecessary pills. Diabetics who are so unnerved by the clinic that their blood sugar rises in a stress response have "white-coat hyperglycemia." People who take their medicines on schedule only when they are about to show up for a doctor's visit exhibit "white-coat compliance."

Many doctors have taken the hint and now work in street clothes instead.

And even those who still cling to the coat often do so for the most pedestrian reasons. For women, it can be just a handy piece of drapery that hides distracting necklines. For men, it can eliminate the need for a choking tie. It may become a piece of virtual luggage, worn for its pockets alone. Occasionally, it can make a very satisfying personal statement that has nothing at all to do with medicine. "The chief wants us all to wear one," a friend said the other day. "So I don't."

Sometimes, though, despite all its other overtones, the white coat can still live up to its full shamanic potential, and then it is a sight to behold.



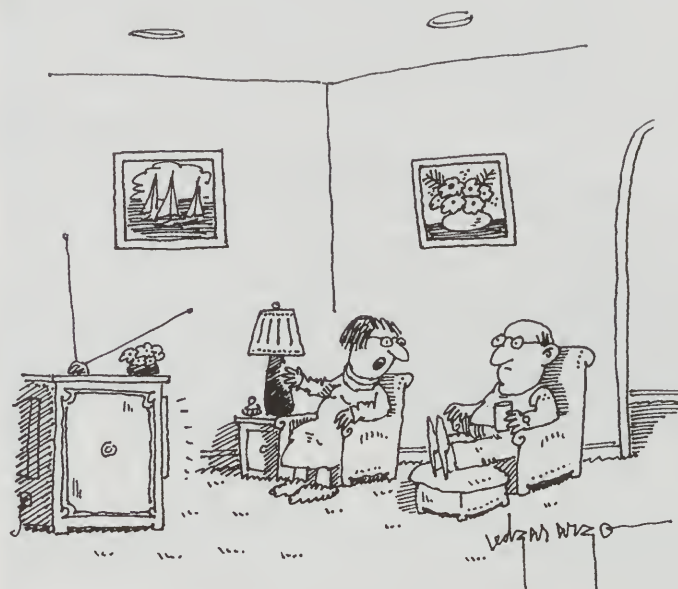
Some years ago, I worked in a municipal hospital whose architects had inexplicably decided that high, narrow windows and taupe wallpaper would speed the healing process. Staff and patients roamed through the deep interior murk like sea-bottom creatures, dingy and depressed. No one ever seemed to get well.

Into the gloom arrived one morning a new member of our team, a Park Avenue doctor doing his pro bono month among the destitute. Every inch of him gleamed, from his sleek pomaded white hair and thin golden spectacles down to his glossy black shoes. His coat was from another era: snowy, thick 100 percent cotton fastened with braided cotton toggles all the way down his expansive front. His pockets were empty.

He looked us over, taking in the stained denim, rumpled khaki and occasional grayish cotton-poly rag, and winced. In revenge, we took him to evaluate an elderly woman who had refused to speak to any of us except in obscenities for days.

He reached into the lump of bedclothes for a hand and cradled it in both of his. "Hello, dear," he said in a full honied bass. "I'm Dr. Bernstein."

She opened her eyes, saw all that whiteness and unfolded like a rose. Ten minutes later, the two of them were sitting side by side on her bed, making animated plans for her discharge. They paid no attention to the rest of us at all.



"I wonder how they find so many doctors with all that acting talent!"

LETTERS

Recharge your batteries

Being a physician also means being a teacher, and that's fortunate because there is still so much need for education about health care. The ISMS Speakers Bureau provides the opportunity for physicians to teach others about health care. You can choose to volunteer as much or as little as you would like. The speakers bureau provides an added benefit: It gives physicians the chance to feel rejuvenated, to serve the community at large and to renew our commitment to patients.

Granted, physicians today have many reasons to feel frustrated. Human nature abhors change, but we must tolerate some uncertainty. We have worked hard to achieve the education and training that physicians today must have. The speed of scientific discoveries and their integration into our daily practice may sometimes distract us from our relationship with our patients. Some of us feel we work

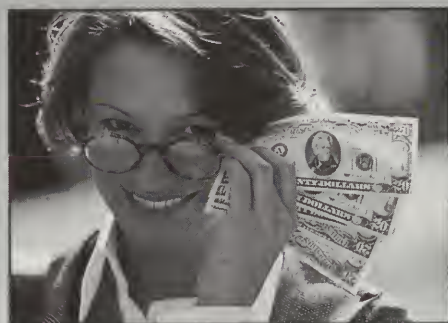
harder for less income, as well as less positive feedback from our patients, their families and the public.

We must also follow the advice we give to our patients; otherwise we will become victims of the stresses of the times in which we live: cardiovascular disease, arterial hypertension, problems with adaptation, and drug and alcohol abuse. We must improve our lifestyles and practice preventative medicine. And, most importantly, we must revisit the dreams that drove us into this lifetime commitment to our patients.

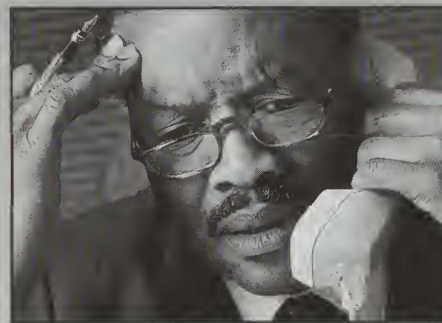
Our ability to educate patients, instill confidence, provide comfort and relief from suffering will be diminished if we are not able to renew ourselves and to recharge our emotional batteries. Taking part in the ISMS Speakers Bureau, and working with willing and curious audiences can provide that renewed energy.

Pedro A. Poma, MD
Chicago

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ISMIE Update

Coming soon:
medical
mishaps

Be prepared for newest malpractice epidemic

Diagnostic errors represent a growing threat. BY EDWARD E. BARTLETT

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Healthcare Risk Management

Try your hand at answering the following five questions:

1. What is the second most common medical malpractice allegation against hospitals?
2. What malpractice allegation is most likely to result in an indemnity payment?
3. What is the leading malpractice allegation in the emergency department, radiology department and pathology service?
4. What is the No. 1 cause of lawsuits against the medical specialties of cardiology, emergency medicine, gastroenterology, internal medicine, pathology, pediatrics and radiology?
5. What malpractice allegation category has more than doubled in claim severity since 1985?

The answer to all five questions is diagnostic errors. If you didn't know that, at least you're in good company. A great many health care risk managers are amazed to find that diagnostic errors are responsible for such a huge proportion of malpractice lawsuits.

Skeptical? Take a look at the specific answers to those questions:

1. About 20 percent of lawsuits against hospitals are for diagnostic errors (including failure to monitor and diagnostic delays), making this the second most common cause of loss, according to closed claim reports from the U.S. General Accounting Office, the Ohio Hospital Association and St. Paul Insurance Co.
2. Lawsuits for diagnostic errors result in indemnity payments 24.1 percent of the time, making this the hardest allegation to defend, according to the GAO.
3. Failure to diagnose accounts for about half of all emergency department claims,



Bruno Budrovic/SIS

two-fifths of radiology claims and about three-fifths of pathology claims.

4. Failure to diagnose is the No. 1 allegation in these physician specialties: cardiology (23.4 percent of claims), emergency medicine (48.4 percent), gastroenterology (29.2 percent), internal medicine (27.5 percent), pathology (58.5 percent), pediatrics (30.9 percent) and radiology (41.6 percent), according to the Physicians Insurance Association of America.
5. The average indemnity payment for failure to diagnose has increased from \$85,778 in 1985 to \$221,704 in 1996, a 258 percent increase over a 12-year period, according to the PIAA.

Diagnostic errors represent a growing threat to quality of care. A growing number of hospitals are facing their first million-dollar lawsuits for failure to diagnose. In the past, risk managers were reluctant to target this category of claims because they were reluctant to tread on

what they perceived as the physicians' territory. That must change, or hospitals will face devastating losses.

As if those data aren't enough cause for concern, the picture is likely to get worse for hospitals in the near future. Diagnostic errors are likely to spark even more lawsuits as hospitals expand their ambulatory services and snap up physician practices. Also, plaintiffs'

attorneys always are on the lookout for deep pockets and are more successfully using the theory of vicarious liability to pin the blame on hospitals.

TROUBLING CASE STUDIES

Here's an example that illustrates some of those distressing statistics: A woman with a prior history of pancreas problems came to the emergency department at 3:30 p.m. with high epigastric pain. Blood work was ordered stat. Her lipase was 2,200 and her amylase was 271. But the emergency department technician accidentally reversed the values, advising the doctor that the lipase was 271 and the amylase was 2,200. The doctor made a diagnosis of pancreatitis, ignoring the elevated CPK value of 296 and the MB band of 38.6 ng. The patient died that night of myocardial infarction.

Like many malpractice lawsuits we see, the injury resulted from a breakdown in the system. The hospital had no computerized laboratory system, which could have prevented the snafu. The technician wasn't thinking, or maybe he was pulling a double shift. The doctor made an error known as "track thinking," being unduly swayed by the patient's prior history of pancreas problems, becoming prematurely committed to the diagnosis and conveniently ignoring the dangerous CPK and MB band values.

Here's another example involving an obstetrical patient: A small hospital compensated for a shortage of area physicians by having the obstetrical nurses assume a major role in patient

monitoring. A patient in her 36th week of pregnancy was admitted to labor and delivery. Electronic fetal monitoring revealed moderate abnormalities. In discussing her progress with the doctor, the nurses underplayed the abnormal tracings. When things started to go wrong, the nurses tried to cover up their mistake by misinforming the pediatrician about the low Apgar scores. The child later proved to be mentally retarded and partly blind.

Here again, there was enough fault to go around. The physicians were remiss in not being more involved in the patient's care. The nurses appeared more interested in preserving their clinical prerogatives than assuring quality of care. And the hospital administrators apparently condoned this tinderbox arrangement.

MAMMOGRAPHY CONCERNS

One area of concern for risk managers is the growing role of screening mammography for women in their 40s, a service often provided in hospitals. Mammography has a higher false-positive rate for premenopausal women with dense breast tissue. A National Institutes of Health Consensus Development Panel concluded in January 1997 that "the data currently available do not warrant a universal recommendation for mammography for all women in their 40s." Unfortunately, a group of Congressional activists overruled the NIH recommendation, pushing President Clinton to endorse mammogra-

(continued on page 10)

MALPRACTICE ROUNDUP

Obstetrician can be sued for emotional distress

A California appellate court ruled that a woman can sue her obstetrician for emotional distress resulting from the physician's breach of duty to provide proper care to her and her fetus, which was stillborn.

In *Zavala vs. Arce*, as cited by the December 1997 issue of *Medical Malpractice Law & Strategy*, the physician's attorney said that a wrongful death action could not be brought for the death of an unborn child. The fetus' death had been discovered before delivery.

The patient's attorney argued that part of the physician-patient relationship with a pregnant woman is the physician's duty to care for the fetus. She explained that any negligent action that causes injury to the child and, thus, emotional distress to the mother should be actionable. The court agreed, writing that "a mother forms a sufficiently close relationship with her fetus ... so that its stillbirth or injury will foreseeably cause her severe emotional distress."

Waves of opposition call for ERISA liability protection

Self-insured plans should be held liable when their decisions harm patients.

BY JANE ZENTMYER

Self-insured health plans got a break from a myriad of state laws when the Employee Retirement Income Security Act became law in the 1970s. But now, more than 20 years later, some say ERISA has been interpreted in ways Congress never intended.

Courts have ruled, for example, that ERISA plans can't be sued under state medical malpractice laws and instead must be governed by more lenient federal laws limiting an injured patient's compensation to the cost of a denied medical benefit. This can leave physicians and hospitals – even if they make all the right decisions – holding the bag in state courts.

"We believe insurance companies and managed care plans are, in effect, practicing medicine with their directives and their specific protocols physicians can and can't use," said M. LeRoy Sprang, MD, chairman of the ISMS Board of Trustees. "If they feel their actions are not accountable, they're obviously much more likely to be restrictive in the care patients can receive, and what they will and won't cover. But, if they realize they have liability for their decisions, they're going to have to act accordingly."

U.S. Sen. Richard Durbin (D-Ill.) is sponsoring S.1136, a federal bill that would end the exemption from state malpractice laws currently enjoyed by ERISA plans. These plans are formed when employers set aside money to pay for the health expenses of their employees. Employers can administer the self-insured plan themselves or hire outside insurance companies, also known as third-party administrators, to do it. The American Medical Association supports Durbin's bill.

"The reality of medical practice is that many providers, many doctors, are limited by the insurance companies they are affiliated with," Durbin said. "I have heard doctors arguing over the phone with clerks at insurance companies about admitting patients. Unfortunately, insurance companies are playing a larger role in medical practice."

The increased role of insurers can affect a patient's outcome, Durbin said. He cited this exam-

ple: A Pennsylvania man sought treatment at a community hospital because of numbness in his arms and an inability to walk. The hospital's emergency room physician concluded that the man had a cervical epidural abscess that would cause severe paralysis unless treated immediately by a spinal cord trauma unit. At 12:30 p.m., the physician began making arrangements to send his patient to a nearby university hospital, the only facility in the area with a trauma



Antoine Savolainen/SIS

ould sink

n

unit that would accept him immediately.

The patient's employer-sponsored HMO, however, denied the transfer because the university hospital wasn't part of the plan's network. Despite the physician's attempts to transfer his patient elsewhere, the patient didn't get the necessary treatment at an appropriate facility until 3:30 p.m. He now suffers from permanent quadriplegia resulting from the abscess compressing his spine. A court decided that ERISA shielded the HMO from a state medical malpractice lawsuit – a decision that left the hospital and physician liable for the patient's medical bills despite their timely and appropriate efforts to treat him.

"What physicians are saying – and quite frankly the courts have been mixed on this – is that [plans] are having an impact on the delivery of health care. They're saying who gets care and when they get care," said AMA Secretary-Treasurer D. Ted Lewers, MD. "That's not the administration of a benefit program. That's becoming involved in the delivery of health care itself."

Critics have argued it's hypocritical for physicians to support an expansion of liability, particularly with their own efforts to enact tort reforms. Dr. Sprang explained, however, that physicians support tort reforms to reduce the number of frivolous lawsuits, adding "We have always thought if a physician, hospital or health plan is responsible for a bad outcome, then they should be held accountable."

Pending federal bills seek to close the liability loophole allowed under ERISA. In addition to Durbin's Senate bill, Rep. Charles Norwood (R-Ga.) is trying to resolve the issue with two different bills. H.R. 1415, also known as the Patient Access to Responsible Care Act, includes provisions eliminating ERISA's pre-emption of state laws. Although the AMA supports the bill's ERISA language, it has no position on the entire bill because of its other provisions. Norwood has put the ERISA liability provision into a separate bill, H.R. 2960, which the AMA supports.

Norwood spokesperson John Stone said the bill does not overturn all ERISA pre-emptions; it only eliminates the pre-emption of state medical malpractice laws. He explained, "If an insurance company makes a medical decision to deny, delay or restrict care – and that decision results in injury, illness or death – under our bill you could sue the insurance company for medical malpractice under existing state laws."

At least one state hasn't waited for Congress to fix the problem. Last summer, Texas enacted a law that would make its state medical malpractice laws applicable to self-insured health plans. But, before the law's impact could be felt, the law was put on hold when Aetna challenged its constitutionality in federal court,

"I have heard doctors arguing over the phone with clerks at insurance companies about admitting patients. Unfortunately, insurance companies are playing a larger role in medical practice."

said Connie Barron, associate director of legislative affairs for the Texas Medical Association. The court had not made a decision before this issue of Illinois Medicine went to press.

During the legislative debate on the bill, businesses expressed concern that they could be sued for the actions of companies hired to administer their health plans. They also argued that it's the third-party administrators who manage the plan's day-to-day operations and make the decisions that potentially affect patient care, Barron said.

The bill approved by the Texas Legislature included provisions that would protect employers. For example, the law calls for an independent panel to review a case before it can go to court. "We wanted to make it clear that it is not our intention that the employer should be able to be sued," Barron explained. "If they're not making treatment decisions, then they're not involved in those actual medical necessity kind of determinations. They cannot have any liability under our bill. The entity that is contracted with them is responsible." (The pending federal bills – S.1136 and H.R. 2960 – include similar protections for employers.)

Critics also charged that physicians shouldn't be working to expand liability. But, Barron said, the TMA explained it wasn't advocating giving patients new grounds to sue health plans. Instead, the liability established under existing laws should fall on those who make decisions that harm patients, she said.

"Often in these cases the doctor didn't do anything wrong and, in fact, the physician fought with the managed care company to try and get the care covered, and to provide the necessary documentation," Barron said. "Because of the way the HMO handled its business and delayed or inappropriately denied those services, they're the ones who should have the responsibility."

The TMA recently started the Campaign for Health Care Accountability to develop grass-roots support to help resolve the liability issue at the federal level. Several organizations have already joined, and TMA is recruiting more for the effort. Barron said the public is amazed when it discovers that health plans can walk away from any responsibility for their actions.

Although objections were raised during the debate, Barron said the Texas bill eventually sailed through the Legislature. The bill's sponsor, she said, repeatedly asked the following question: Why should these organizations get special treatment when every other business is held accountable for its actions? "No one could answer that question," Barron said. ■

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Be prepared

(Continued from page 7)

phy for women in their 40s. As a result, routine mammography for younger women is becoming the standard of care despite its documented problems, which will tend to increase failure-to-diagnose lawsuits for these women.

The fact that diagnostic error claims are the most difficult to defend argues that health care risk managers need to take a proactive approach. These are some of the actions you can take:

- Promote policies and procedures designed to reduce failure-to-diagnose claims. Especially important are procedures for telephone calls from patients and for emergency triage, nurses' roles in obstetrical monitoring, postoperative monitoring, evaluation of patients on intravenous and parenteral medications, assessment of suicide risk, communication of abnormal radiological and laboratory results, and patient discharge instructions.

- Assure proper physician credentialing, especially among contract emergency-department groups. In the past, credentialing in some hospitals was swayed too much by economic and political considerations. It is crucial to implement a strict and objective credentialing process, and to ensure that the risk manager has a valid role in that process.

- Disseminate diagnostic protocols to physicians. In coordinating a broad-based effort to develop diagnostic protocols for breast cancer, colorectal cancer and acute myocardial infarction over the

past three years, I have found that physicians are receptive to practice guidelines if they have been involved in their development.

- Offer continuing education for physicians and nurses. As much as possible, seek continuing education that offers practical, real-world examples to the clinicians. The case study method is useful in illustrating common barriers that lead to diagnostic errors, highlighting them and then asking the physicians to analyze one of their own diagnostic mistakes.

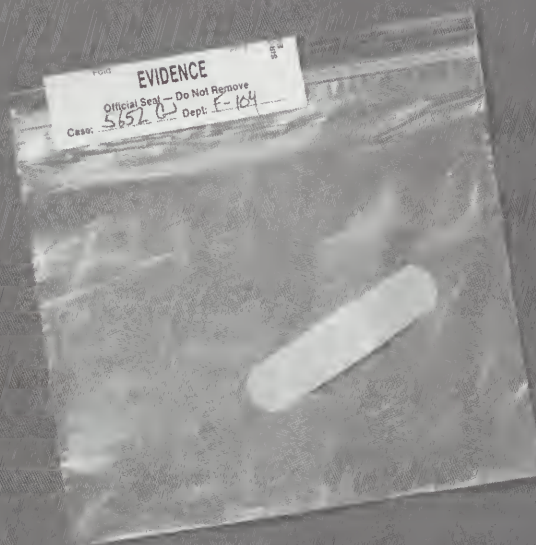
- Encourage good working relationships among the various hospital departments. For example, consultation requests should be as specific as possible. It's better to use "R/O arrhythmia" instead of "cardiac evaluation." If a serious abnormality is detected in a radiological or pathological study, the referring doctor should be advised by telephone. Nurses should not be reluctant to seek a physician's advice.

- Support ongoing quality improvement efforts. In addition to the improvement it can bring, a quality improvement program is an effective way to monitor the ongoing effects of your loss prevention efforts.

Through those steps, risk managers can take a proactive approach to reducing diagnostic errors and resulting malpractice lawsuits. But before any effective countermeasures can be employed, risk managers must realize the frequency of diagnostic errors and dispel the notion they are beyond the control of risk management. That may be the biggest challenge. ■

Exhibit A:

Adhesive bandage, which plaintiff alleges defendant pulled rapidly from skin, violently tearing three hairs from plaintiff's arm, which resulted in severe shock, trauma, disfigurement, chronic debilitating pain and permanent psychological damage.



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HCFA sidelines

(Continued from page 1)

responsibilities – not even the government.”

HCFA's proposal no longer recognizes medical staffs as a separate independent entity that has the responsibility for the quality of medical care, explained Elizabeth Snelson, an attorney for hospital medical staffs. The rule lists a hospital's medical staff as part of human resources, much like other hospital departments, such as nursing.

“In essence, the medical staff isn't an organization that works in the hospital,” she explained, referring to the new rule. “Rather, it's a department with personnel that work in, work for and are employed by the hospital.”

The rule also deletes existing language that made medical staffs responsible for the quality of care provided to patients.

“It's almost as if HCFA is in this ivory tower and has not been in a hospital or doctor's office in the last 10 years,” Snelson added. “Hospitals are so desperately trying to keep afloat that the pressure on them to cut as many financial corners as possible is very high.”

Without a medical staff to offer checks and balances to a hospital's financial pressure, the quality of care received by patients may suffer. For example, Snelson said administrative officials – instead of the medical staff – may control which physicians can have clinical privileges at the hospital. Those officials may choose not to grant privileges to physicians treating patients who don't make money for the hospital, such as those with HIV.

“What HCFA is proposing would weaken [medical staffs] greatly at exactly the wrong time,” Snelson said. “We need to make [them] stronger, especially in Illinois.” In October 1997, the Illinois

Supreme Court struck down the corporate practice of medicine, citing the existence of independent medical staffs as one factor that could protect physicians and their decisions from complete control by hospitals, Snelson said. “That would be great, if it were true.”

Another controversial provision in the rule allows certified registered nurse anesthetists to practice independently. HCFA currently requires operating physicians or anesthesiologists to supervise CRNAs, but the rule would eliminate this requirement for physician oversight. It does not, however, usurp CRNA

practice standards and supervisory requirements established by the states.

“Anesthesiology is the practice of medicine,” Rodney Osborn, MD, an anesthesiologist and an ISMS Fourth District trustee, said in a letter to HCFA. “Increasingly difficult surgical procedures coupled with complex interactions between anesthetic agents and patients' medications for pre-existing diseases make the immediate input of a physician qualified to administer anesthesia vital to the care of every surgical patient.”

Dr. Osborn pointed out that people in Medicare and Medicaid are often the

sickest patients, and they need the safest anesthetic care available. A recent clinical study found that the lowest death rates occurred at institutions with board-certified anesthesiologists on a hospital's medical staff, he said. “Anesthesia today remains safer than ever before thanks to the efforts of physicians who have devoted their careers to clinical practice, research and teaching.”

If you would like to comment on the rule, send a letter to the U.S. Health Care Financing Administration; Attention: HCFA-3745-P; P.O. Box 7517; Baltimore, MD 21207-0517. ■



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EPORT for Illinois Physicians

Utilization Recommendations for Inpatient Preoperative Bowel Preparation

To decrease the risk for post surgical complications (sepsis, wound infection, abscess formation, wound dehiscence, anastomotic leaks), it is essential that the colon is adequately cleansed prior to elective colorectal and some GU and Gyn surgical procedures. Polyethylene glycol (Golytely, Colyte), given as an oral colonic lavage is the most commonly used solution for mechanical bowel preparation because of its effectiveness and lack of side effects. This preparation is well tolerated and can also be given safely and effectively in the outpatient setting to adults and children.^{1 2 3}

Outpatient bowel preparation is as effective as inpatient bowel preparation for elective colorectal surgery and does not increase the risk for surgical complications.^{2 4} In a prospective, randomized trial of 100 patients undergoing elective colorectal surgery, there was no difference in the adequacy of the bowel prep or wound infection rate in those patients who received the bowel preparation at home when compared with patients who received the bowel prep in the hospital.²

However, with certain medical conditions and surgical procedures it may be appropriate to admit patients for inpatient bowel prep. These conditions may include:

- Severe fluid and electrolyte abnormalities such as hypokalemia.
- History of significant recent lower GI bleed.
- Children or adults requiring NG administration of prep solution.
- Nausea, vomiting, abdominal pain or evidence of bowel obstruction.
- Extensive GU surgery, i.e., cystectomy and formation of an ileoconduit.
- Extensive Gyn surgery, i.e., pelvic exenteration.

Patients with the following conditions may receive bowel prep as an outpatient with assistance and supervision:

- Functionally Debilitated (History of CVA, Arthritis, Paraplegics/Quadriplegics).
- Mentally incompetent (dementia, psychiatric illness).
- Children less than 12 years old because of potential for dehydration.
- Patients with comorbid conditions such as diabetes, renal failure and CHF who may require supervision.

Home Health Care may be of assistance in the cases that require supervision. Our utilization management staff may assist in identifying HH Agencies that can provide this service.

¹ Frazee RC, Roberts J, Symmonds R, Snyder S, Hendricks J, Smith R. Prospective, randomized trial of inpatient vs. outpatient bowel preparation for elective colorectal surgery. *Dis Colon Rectum*, 35: 3, 1992 Mar, 223-6.

² Tuggle DW, Perkins TA, Tunell WP. Outpatient bowel preparation in Children. *Pediatric Surgery*, 24:7, 1989 Jul 703-4.

³ Philip RS. Department of Surgery, Kaiser Permanente Cleveland Medical Center, OH. Efficacy of preoperative bowel preparation at home. *American Surgery*, 61: 4, 1995 Apr, 368-70.

⁴ Solla JA, Rothenberger DA. Department of Surgery, University of Minnesota, Minneapolis. Preoperative bowel preparation. A survey of colon and rectal surgeons. *Dis Colon Rectum*, 33:2, 1990 Feb, 154-9.



Amy Rothblatt

KRIS JOHNSON, Assistant Director for ISMS Professional Relations, was recently honored with the ISMS Employee Recognition Award. She was praised for her pleasant demeanor, organizational skills and efficiency, as well as her dedication and service to the Alliance.

Illinois House

(Continued from page 1)

the details of written collaborative agreements. ISMS, unlike INA, wants APRNs to have agreements only with physicians who have a similar scope of practice. For example, a nurse midwife would have an agreement with a physician who practices obstetrics. Although both groups agree that nurse practitioners, clinical nurse specialists and nurse midwives should have agreements, INA disputes the need for nurse anesthetists to have one.

ISMS' bill also limits physicians to two collaborative agreements with nurse

practitioners, clinical nurse specialists and nurse midwives, and four agreements with nurse anesthetists. INA doesn't support the restrictions. ISMS supports giving APRNs delegated prescriptive authority for Schedule III through V drugs. The INA, however, also wants prescriptive authority for Schedule II drugs.

Despite these differences, Dr. Jackman said ISMS "remains committed to a continuing dialogue with all interested groups and open to efforts to develop a unified approach to APRN licensure that we could join in recommending to the General Assembly."

Illinois is the only state that doesn't

license APRNs. Although the Illinois Senate hasn't held any hearings on the issue, the Senate leadership and sponsors of the pending APRN Senate bills have met with ISMS and INA to urge the groups to resolve their differences. If the two groups can't reach an agreement, the senators may take it upon themselves to craft a bill that works out the differences for them, said Sen. Doris Karpel (R-Roselle), the lead sponsor of the Senate bill supported by ISMS.

"This has been going on for a couple of years and both sides have moved quite a bit, particularly the doctors [who] have moved substantially from two years

ago," Karpel said. "While we have the momentum, we should keep it going, keep them negotiating and get something done. I feel that if we don't do it this year, we may have to start from square one."

At the House hearing, Elizabeth Strow, MD, drew upon her experience as an APRN who became a physician to compare the differences in education between the two professions. "Anyone who thinks it's the same is fooling themselves," she said. "My nursing background did not prepare me for the depth and breadth of knowledge that I [received] in medical school."

For example, in addition to the several more years it takes to become a physician, Dr. Strow said the science in nursing programs is much more superficial than the science taught in medical school. Nursing schools also focus on nursing theories while medical schools focus on the sciences and medical theories.

APRNs shouldn't be allowed to practice medicine independently, she added. "As an eighth-year resident in dermatology, I had to sign out every chart with my physician to make sure that what I was doing was good medical practice," Dr. Strow said. "I quite frankly can't believe that nurses out there want to practice independently with their background. I think they should and would want to have a collaborative agreement with physicians."

On the other hand, Rosemary Meganck, a certified nurse midwife who was a member of INA's advanced practice task force, said APRNs' scope of practice and standards are based upon their education from accredited organizations and upon standards set by their respective professional associations. Clark added INA's bill relies on the professional integrity and judgment of physicians and nurses to determine the best way to meet their patients' needs.

Steven Hall, MD, president of the Illinois Society of Anesthesiologists, pointed out that INA's bill doesn't require physicians to be involved in patient care, particularly if that care involves anesthesia. The ISMS bill does. "CRNAs have been our partners and team members, and they do a marvelous job," Dr. Hall said. "But, they are not the only part of the team. The INA bill would eliminate the team by eliminating the [team's] medical component."

Tax checkoffs benefit research funds

[SPRINGFIELD] Illinois taxpayers have the opportunity to contribute to the Alzheimer's Disease Research Fund, and the Breast and Cervical Cancer Research Fund through their 1997 tax returns. The Illinois Department of Public Health oversees both funds.

The Alzheimer's research fund has appeared on the state tax form for 11 years and has received over \$1.6 million to support more than 80 studies, according to IDPH. The checkoff is on Line 15c of the 1997 IL-1040. The breast and cervical cancer fund checkoff, found on Line 15e, is in its fourth year and has helped underwrite 28 research grants for prevention, early detection and treatment studies.

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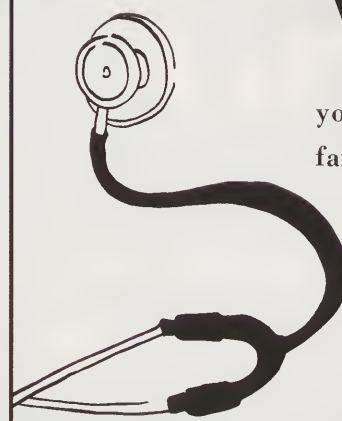
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Sunny economy

(Continued from page 1)

paid promptly under the 1999 budget, which will assure payment to more than 42,000 Medicaid providers in an average of less than 25 days.

The budget keeps the rate paid to Medicaid providers at last year's level. However, the governor favors a 3 percent increase if the funding can be found. He called on the General Assembly to provide funding for such a rate adjustment for Medicaid providers in fiscal 1999. The legislature would need to approve a bill to appropriate the added \$120 million annual cost of this increase. The last rate increase was 3 percent in fiscal year 1997.

The governor initially made the hike contingent on passage of an insurance tax to replace a 2 percent levy on non-Illinois insurers ruled unconstitutional in October by the Illinois Supreme Court. After some legislators expressed doubt the tax would pass in an election year, the governor indicated he'd be willing to consider other funding options, according to John Webber, a spokesperson for the governor's office.

Revenue lost by the court's rejection of the tax is roughly equal to the cost of the 3 percent rate adjustment, which is why the governor linked the two items, Webber said. The Illinois Department of Insurance recommends replacing lost revenue with a tax on all insurance companies: 0.4 percent for health insurance companies and HMOs; 0.5 percent for all others.

Illinois' glowing fiscal forecast is in step with a federal budget that will be in the black this year for the first time in a generation. The state's fiscal well-being is being attributed to a thriving economy and careful spending. "This budget is energized by the economic vitality of Illinois today," Edgar told the General Assembly.

Children's health insurance coverage is also the recipient of new proposed revenues. The budget includes \$117 million to extend health coverage to tens of thousands of children whose families earned too much to qualify for Medicaid, but not enough to afford private health insurance, the governor said. The first

phase of this initiative, KidCare, began last month, and Edgar has appointed a special task force to draft a legislative proposal for implementing its second phase in fiscal 1999.

If approved, the budget proposal will fund some substantial health care spending increases: a 23.9 percent hike in home health care, attributed to the growing use of those services; an 18 percent boost for transportation, accommodating an IDPA effort to increase access to services; and a 14.8 increase in drug spending due to new federal mandates.

It will also give the Illinois Department of Public Health an increase of nearly

\$1.3 million to be used for grants to local health departments, including a more than 100 percent jump in the minimum funding level for rural health departments. It also includes \$1 million in new general revenue spending for the fledgling Office of Women's Health, which started last May on a shoestring budget.

Last year there was little money for the women's health office in the general revenue fund — \$279,000 — and the office was started late in fiscal 1998, said Tom Schafer, spokesperson for the IDPH, which oversees the office. "The intention all along was to further upgrade it when the new budget came around." ■

Eight-year low for Illinois teens giving birth

[SPRINGFIELD] The number of babies born to Illinois teens decreased to the lowest level in eight years, according to the Illinois Department of Public Health.

Of the 183,079 babies born in Illinois in 1996, 23,331 — or 12.7 percent — were born to women 19 years old or younger. This is a decrease from 12.9 percent in 1995, and the lowest since the 12.5 percent recorded in 1988. About 85 percent of these teen-agers giving birth were single mothers.

Federal studies cited by the IDPH have found that sexual activity among teens has fallen for the first time in 25 years. The National Survey of Family Growth,

conducted every five years, found half the 15- to 19-year-old women reported having sex at least once, down from 55 percent in 1990. A similar U.S. Department of Health and Human Services study reported that 55 percent of teen-age boys said they were sexually active, down from 60 percent in 1988. Researchers suggested that fear of HIV infection and AIDS, better sex education at school and an increased concern about having a child were among the reasons.

IDPH Director John Lumpkin, MD, said he hopes teen-agers may be changing their attitudes about early sexual activity and its consequences. "Despite

the encouraging trend, there are still too many babies born to teen-agers," he said. "Abstinence remains the best choice and that message needs to be delivered by those of us who influence their lives — family, preachers, teachers, health care providers and friends."

ISMS has endorsed Parents Too Soon, a contract-based, \$8 million Illinois Department of Health and Human Services program designed to help prevent pregnancies among women 21 years old and younger.

Additionally, ISMS' teen health program on sex, HIV and other sexually transmitted diseases stresses abstinence as the best means of preventing the spread of disease. For more information or to volunteer for the ISMS Teen Health Speakers Bureau, call (800) 782-4767. ■

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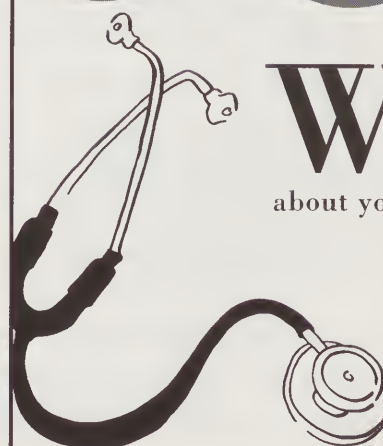
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Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • APRIL 3 1998

ISMS provides
CME activities
to physicians

PAGE 2



Andrew Corrigan Halpern

AMEE BASS (right) a medical student at the University of Illinois-Chicago, phones home with the news that she will intern in pediatrics at Lutheran General Hospital, as her sister, Sara, shares her joy. The much-anticipated Match Day was March 18.

OMSS meeting agenda focuses on self-defense

LESSON: Weapons available in the struggle against managed care abuses. BY LINDA MAE CARLSTONE

[CHICAGO] Participants in the recent ISMS Organized Medical Staff Section's annual meeting offered this advice for physicians facing attempts by managed care plans to diminish their control: Don't give up, and learn to fight back. Unionization, contract scrutiny and legislation are some of the weapons available in the tug-of-war with managed care plans that were outlined for physicians at the OMSS meeting conducted March 14 at ISMS Chicago headquarters.

Rockford physician Dennis Norem, MD, gave a first-hand account of how "loss of control" drove some physicians employed by Rockford Health Systems to seek collective bargaining. The slippage started in 1994 when the Rockford Memorial Health Services Corp. acquired the clinic, he said. "Decisions became budget-driven," he said, adding that the hardest blow was a major downsizing that cut staff by 10 to 15 percent.

Since the takeover, there had been discussions about giving

physicians a stronger hand in leadership, but the offers didn't materialize, he said. "Consultants made recommendations and meetings were held, but things didn't get better." After three years, some physicians formed the Rockford Physicians' Council to launch a movement to win the right to collectively bargain. The group met with the AFL-CIO, but rejected affiliation with the traditional labor (Continued on page 14)



Dr. Norem

INSIDE

MSAs and
medicine's free
market component

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DEPARTMENTS

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Physician-friendly candidates triumph

RESULTS: Winners in primaries now look to November's general election.

BY JANE ZENTMYER

[CHICAGO] On St. Patrick's Day, the luck of the Irish rubbed off on physician-friendly candidates, many of whom defeated tough opponents to win their party's nomination in the March 17 primary election.

It was more than just luck, however, that helped these candidates get elected. "The Illinois State Medical Society Political Action Committee made a clear and convincing difference in the primary election," said Jere Freidheim, MD, the IMPAC Council chairman. "IMPAC provided physician-friendly candidates with financial and grass-roots support that helped carry them to victory."

Managed care reform became a hot topic in several legislative primary battles, particularly after business groups targeted pro-reform incumbents for defeat. At the top of their hit list was Rep. Carolyn Krause (R-Mount Prospect), a sponsor of the ISMS Managed Care Patient Rights Act and Republican spokesperson for the House Health Care Availability and Access Committee.

The business groups' efforts failed, however. Krause decisively defeated her



opponent 65 percent to 35 percent, according to unofficial election results. Rep. Rosemary Mulligan (R-Des Plaines) – another strong reform supporter – defeated her challenger 57 percent to 43 percent. In these two districts, more than 250 physicians received IMPAC letters asking them to support the physician-friendly candidates.

State Rep. Judy Biggert (R-Westmont), another strong reform supporter who was targeted by business groups, may soon be in Washington. IMPAC provided Biggert with significant support, and she was the winner in the six-way Republican primary battle for the chance to replace retiring U.S. Rep. Harris Fawell, a Republican from Clarendon Hills. Her closest challenger was state Rep. Peter Roskam (R-Wheaton), a plaintiff's attorney.

An upset in the Democratic primary for a state Senate seat in Chicago put a physician-friendly candidate on the ballot this November. Antonio Munoz of Chicago defeated incumbent Sen. Jesus Garcia (D-Chicago) 54 percent to 46 percent for his party's nomination.

(Continued on page 13)

CHIP extends safety net to individuals

ACCESS: State fulfills federal insurance portability law. BY JANE ZENTMYER

[CHICAGO] The federal Health Insurance Portability and Accountability Act of 1996 was designed to help people like Amy Gardner. Suffering from renal reflux hypertension, Gardner successfully received a kidney transplant while she was in college. Now 27, she spends at least \$2,600 per month on drugs and blood work to guard against a possible rejection of the kidney.

Her medical history ties her career advancement opportunities to an employer's ability, or lack thereof, to provide health insurance covering the costs related to her transplanted kidney, Gardner said. For example, she accepted a position that came with needed health benefits, but the job wasn't in her chosen field of child care.

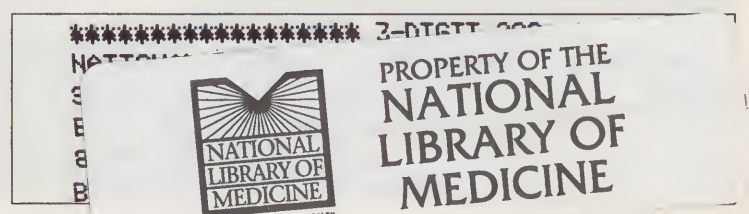
When the Comprehensive

Health Insurance Plan set up a new health plan with no waiting periods or pre-existing condition exclusions, Gardner, knowing she could receive insurance through CHIP's new plan, accepted a job caring for six children in their parents' home. "This relieves a huge amount of stress for me because now I have the ability to do the things I want," she said. "Before, I had to find insurance any way I could."

CHIP's new insurance product – created to implement HIPAA in Illinois – could benefit an estimated 4,000 to

11,000 Illinoisans like Gardner, who seek insurance in the individual market, said Richard Carlson, CHIP's executive director. These usually are people who have left a job with group coverage to become self-employed, taken early retirement or been laid off.

After a six-month trial period, CHIP formally introduced its new product to the general public at a February news conference at the Rush-Presbyterian-St. Luke's Medical Center in Chicago. At (Continued on page 14)



ISMS provides CME activities to physicians

LAW: Medical Practice Act requires 50 CME hours per year. BY JANE ZENTMYER

[CHICAGO] When the Illinois Department of Professional Regulation recently released a proposed rule outlining how physicians can fulfill their 50-hour continuing medical education requirements, ISMS was quick to point out its continuing emphasis on assisting physicians with their CME.

The Medical Practice Act requires physicians to earn – and document – 50 CME hours each year. Dean Bordeaux, MD, chairman of ISMS' Committee on CME Activities, said the Society is one state organization that can help physicians meet the act's requirements.

"Illinois has been at the cutting edge of continuing medical education since the 1970s," said Dr. Bordeaux. "The state and ISMS have been leaders in developing standards and objectives for CME activities. The Society is positioned well to assist Illinois physicians."

In 1997, the Society offered 69 CME activities for a total of 168.75 hours of Category 1 credit. More than 1,100

physicians – and more than 400 non-physicians – attended the programs.

Most of the CME activities focus on risk management and practice management issues that typically arise in councils and committees, Dr. Bordeaux said. He cited "An Essential Office Practice" as an example of a popular seminar presented through ISMIE.

Physicians who complete this program can develop and implement effective office risk management strategies. They also ought to come away with the knowledge needed to explain the significance of communication in preventing patient injury and litigation, describe the principles of good medical record documentation, develop office procedures for medical record access and retention, implement guidelines for patient follow-up, and summarize the legalities in the treatment of minors.

From April to November, ISMIE will present 19 of these office practice seminars across the state. Program

attendees can earn a maximum of three hours of Category 1 credit toward their annual CME requirements. Seminar locations include Chicago, Oak Brook and Collinsville. Physicians living in rural areas can benefit from the multiple seminar sites around the state, Dr. Bordeaux said. "There are a lot of ways physicians can get credit without having to travel very far."

ISMS also helps county medical societies develop their own CME programs, with clinical issues occasionally being incorporated into their offerings. "County societies are considered to be components of ISMS," Dr. Bordeaux said. "That doesn't mean we necessarily handle the logistics [of the county CME programs]. We oversee the process to make sure it meets the essentials and standards of the Accreditation Council for Continuing Medical Education."

When developing programs, the Committee on CME Activities determines if the activity has identified the needs of physicians and then translated those needs into specific educational objectives physicians can accomplish at a program, Dr. Bordeaux explained. It then focuses on the best way to present the information. Once the program is completed, Dr. Bordeaux said, the committee decides if the objectives were achieved.

ISMS also accredits other organizations, such as hospitals and specialty societies, to develop their own CME programs. In 1997, 55 Illinois organizations were accredited intrastate sponsors. These groups follow the same guidelines as ISMS to develop its programs. ISMS is one of only a few societies across the country that both provide CME and authorize other organizations to provide it, Dr. Bordeaux said.

Physicians who have questions about the CME requirement may contact ISMS' Education and Licensure Division at (800) 782-4767 or (312) 782-1654, ext. 1165.



Highlights of Illinois' proposed CME rule

- Physicians will need 50 hours of CME for the July 1999 license renewal cycle. Any hours earned after July 1997 will count toward this 50-hour total.
- After the 1999 renewal cycle, physicians must earn 50 hours of CME per year, for a total of 150 hours during a three-year cycle. At least 20 hours out of the 50-hour total must be formal, or Category 1, hours. No more than 30 hours out of the 50-hour total can be informal, or Category 2.
- Physicians can earn the American Medical Association's Physician's

Recognition Award to meet their CME goal. The PRA requires 150 CME hours over three years; it doesn't limit the hours a physician can earn in one year. The 150-hour total must have at least 60 hours of Category 1 and up to 90 hours of Category 2.

- The renewal application will ask physicians if they've earned the required CME. Supporting documentation will not have to be sent with the application. Instead, IDPR will request documentation from a certain percentage of applications it chooses to audit.

IMPAC Annual Meeting scheduled for April 24

[OAK BROOK] The Annual Meeting of the Illinois State Medical Society Political Action Committee will take place Friday, April 24, at the Oak Brook Hills Hotel. The meeting is open to all IMPAC members and will begin immediately after the ISMS House of Delegates morning session.

Business will include the election of IMPAC Council members. Nominees for appointment or reappointment to the council are Paul Mahon, MD, Springfield; Dennis Brown, MD, Schaumburg; Richard Geline, MD, Skokie; Richard Jorgensen, MD, Winfield; George Mitchell, MD, Marshall; Richard Quinones, MD, Flossmoor; Mary Ann Stoffel, Moline; Robert Vanecko, MD, Chicago; and George Wilkins, MD, Edwardsville.

The committee also nominated William Kobler, MD, Rockford, to complete the unexpired term (until 2000) of the late Raymond Hoffmann, MD.

African medical center seeks supplies, equipment

[ELK GROVE VILLAGE] The Illinois chapter of Sister Cities International has asked for donations of medical supplies, equipment and cash to outfit a clinic to be built in Cape Coast, Ghana.

The ecumenical medical center has been named for Rev. Philip Kennedy, who served as president and chief executive officer of Alexian Brothers Medical Center in Elk Grove Village. Kennedy also initiated the Illinois Partners for Global Health, an effort that ships medical supplies and equipment to clinics throughout the world.

The clinic named for Kennedy will include treatment and examination rooms, a multipurpose room for meetings, and areas for health education and dental treatment.

For more information about the clinic or to arrange for a donation, call Sister Cities International's local office at (630) 830-9298.

Chicago wins grant for terrorist response team

[CHICAGO] The city of Chicago has received a \$450,000 federal grant to ready a specialized strike team that would come to the quick aid of victims injured in a chemical, nuclear or biological terrorist attack.

Hospital emergency room personnel are likely to be part of the Metropolitan Medical Strike Team, which will be trained for immediate response to attacks from mass-destruction weapons, said Robert Jevic, a staff member of the U.S. Department of Health and Human Services' Office of Emergency Preparedness. A team normally is made up of existing emergency workers from hospitals, police and fire units, he said.

Chicago was one of 25 cities to nab a share of \$9.2 million in contracts awarded by HHS for setting up the special teams.

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Legal steps set for involuntary electroconvulsive therapy

ACTION: Court encourages revision of law. BY JANE ZENTMYER

[SPRINGFIELD] When an Illinois appellate court found the procedures for involuntary electroconvulsive therapy unconstitutional, parents and guardians of mental health patients had no method to OK such treatment for their loved ones.

"The court's action produced a domino effect, in which no courts outside Cook County would hear such cases or grant the necessary approval for involuntary treatment," Illinois Psychiatric Society President Valerie Raskin, MD, explained in a letter to ISMS.

When the Fourth District Appellate Court made its decision last spring, ISMS and IPS jointly developed legislation resolving the appellate court's objections. The result, attached to S.B. 317, sailed through the legislative process, becoming law last summer. "It took less than four months from the day the law was struck down to the day the new law was enacted," Dr. Raskin said.

Meanwhile, the case concluded its legal journey when it reached the Illinois Supreme Court late last year. In January, the seven-member court made the same decision as the appellate court and ruled the old procedures unconstitutional. But, thanks to last year's quick legislative action, the high court's objections had already been addressed.

In re Branning, the case that encouraged the legislative action, involved a patient whose guardian provided informed consent for electroconvulsive therapy despite the patient's stated desire to avoid the treatment. A trial court approved the therapy after listening to the patient's psychiatrist and guardian, according to court records.

The law debated by the court stated that "no recipient of services shall be subjected to electroconvulsive therapy or to any unusual, hazardous or experimental services or psychosurgery without his written and informed consent." A parent or guardian could provide written and informed consent for treatment only with the approval of the court, according to the statute.

"The Supreme Court looked at this law and decided that the protections were inadequate," explained Saul Morse, ISMS General Counsel.

For example, the court noted the law in question didn't require a hearing to determine a patient's capacity, or lack thereof, to make a reasoned decision. The law also didn't require a determination of the patient's specific condition

necessitating treatment or a comparison of electroconvulsive therapy's benefits against other treatments.

Although the trial court did provide some protections in this case by listening to the patient's psychiatrist and guardian, Justice Benjamin Miller wrote in the court's decision that "the statute does not

require that those protections be given in the future."

The court turned to an existing statute on psychotropic medication as an example of appropriate due process procedures. "We believe that treating a ward with electroconvulsive therapy or any unusual, hazardous or experimental services or psychosurgery is of the same character as treating a ward with psychotropic medication," Miller wrote.

The current law for involuntarily administering psychotropic medication requires a hearing to determine a patient's capacity to make decisions, the condition from which the patient

suffers and the benefits of medication compared with the potential harm from using it. The hearing must also determine if less restrictive treatments have been considered and found ineffective. According to the law, treatments can only be approved for a 90-day period, Morse said.

The new procedures adopted for electroconvulsive therapy follow the same lines. When developing its legislation, ISMS and IPS anticipated the Supreme Court would point to the existing law for psychotropic drugs, because the appellate court did so in its decision. ■



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REPORT for Illinois Physicians

MEDICARE BILLING SURGICAL PATHOLOGY SERVICES FOR SKIN SPECIMENS

The purpose of this article is to clarify the billing by a supplier for the technical component (TC) of surgical pathology services for skin specimens. Suppliers who provide these kinds of services typically bill Medicare Part B using CPT® codes 88304 TC, 88305 TC, 88312 TC, 88313 TC and 88314 TC. The most frequently performed services are described by 88304 TC and 88305 TC, as 88312 TC, 88313 TC and 88314 TC are add-on codes.

Under the physician fee schedule, the carrier can recognize payment for the TC of surgical pathology services. In particular, 88304 and 88305 describe the gross and microscopic examination of specimens. The professional component (PC) of surgical pathology for these codes includes the gross and microscopic examination of the specimen by the physician. The gross examination is the visual examination and other activities performed by the pathologist that help in rendering a diagnosis with respect to the specimen. The TC service includes the preparation of the slide for interpretation by the physician, and other usual pre-slide preparation services. The TC of surgical pathology is not subject to CLIA requirements; suppliers providing only this service do not have to apply for CLIA certification.

Some physicians, usually dermatologists, use a supplier to provide the TC service for skin specimens. The dermatologist provides the gross and microscopic examination and the supplier provides the TC service.

Suppliers of this service have two billing options. The physician can purchase the TC service from the supplier and report the service as a "purchased diagnostic test," identifying the amount charged by the supplier and the name of the supplier, including the supplier's provider number. Suppliers who choose this billing option must obtain supplier/provider numbers for each carrier service area where the physician is located. Alternatively, the supplier could bill the carrier directly.

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EDITORIAL

Taking back control

A little more than a month ago, ISMS Third District Trustee Kenneth Printen, MD, told a group assembled for a seminar at the Chicago Medical Society's Midwest Clinical Conference that "If there is to be managed care, physicians have to be the ones managing it." That's a good point, but it's one that some physicians may believe is easier said than done.

Or is it?

Certainly one way to take control of any situation is to learn as much about it and fight it with knowledge. The more you know, the better you can determine your next move. That case can be made with an insurance contract. As hard as it is to believe, some physicians still need to be reminded to read the fine print in the contracts before they sign. As Carol O'Brien, the American Medical Association's director of the Division of Representation, said about contract language pitfalls: There's a reason the print is so fine. They don't want physicians to read it.

That small print can become a legal quagmire for the unsuspecting physician, as described in the feature on contract language on Page 8 of this issue of Illinois Medicine. Clauses that protect only one side, language that's intentionally vague and provisions that fail to recognize the realities of the day-to-day practice of medicine can lead some physicians to impossible contract situations.

Because some managed care

organizations intentionally dissuade physicians from scrutinizing their contracts – one going so far as refusing to allow physicians to read the contracts away from the plan's offices – it is imperative that before you sign any insurance contract, you always read the fine print. Let an attorney take a swing at it as well. The ISMS Lawyer Referral Network is also available to you for legal consultation by calling (800) 545-7876 or (217) 528-5609.

Physicians can also wrest back control of their patient care by better using their organized medicine connections. The American Medical Association, for example, has produced a model managed care contract for physicians and their attorneys to use in reviewing contracts. The model is available by calling (312) 464-5490.

The AMA and ISMS can also help physicians by discussing noneconomic issues with health plans and can represent physicians when they address some economic issues, so long as the efforts don't lead to an illegal boycott against a plan.

It is important not to overlook the power physicians within organized medicine can wield in managing managed care on the legislative front. By lobbying for bans on gag clauses and other egregious violations of the physician-patient relationship, physicians and organized medicine can help create an environment in which the clinical experts are the ones making clinical decisions.

PRESIDENT'S LETTER

Medicine is an honorable profession

Jane L. Jackman, MD



We should insist on being treated as the ethical people we are.

Do the new Medicare evaluation and management code guidelines have you frazzled? Do Stark II rules on physician referral practices leave you bewildered? Do OSHA standards and CLIA regulations give you a major headache? Medicine has become the most highly regulated profession in the United States. Yet there is great doubt in my mind that these onerous regulations improve the quality of patient care. Certainly they add a considerable amount to our overhead expenses and may actually decrease access to care in some instances.

In recent years it has become politically popular for politicians to make frequent pronouncements as to how they must fight fraud, abuse and waste in health care. Curiously, by government estimates the amount of waste always seems to hover around 10 percent of total health care costs. If the politicians know how much money is being spent so wastefully and fraudulently, and who is doing it, I'm puzzled why they don't just lock up the offenders and leave the rest of us alone.

Certainly, all reasonable doctors and other health care workers believe that if one of us truly fraudulently bills the government he or she should be punished. However, medicine is an honorable profession and the overwhelming majority of us are honest and truthful practitioners. We should insist on being treated as the ethical people we are.

Unfortunately, the definitions of fraud and abuse have expanded beyond the traditional definition of intentionally defrauding the government. Today, little distinction is made between fraud and inadvertent mistakes, such as coding and billing errors, or even legitimate issues of medical judgment. Two years ago, the American Medical Association fought long and hard to change the criminal penalties of the U.S. Health Insurance Portability and Accountability Act of 1996. Now prosecutors must prove a

physician has voluntarily and deliberately committed fraud. However, last year this "knowing and willful" standard came under attack, and we anticipate further attempts to weaken it this year. We should not be penalized for inadvertent errors; each of us needs to tell our members of Congress how much this would hurt the practice of medicine.

Probably no issue has galvanized doctors more recently than the need to significantly modify the documentation guidelines for E and M services, which would have gone into effect in January had not the AMA obtained a six-month delay in their implementation. The AMA is now working on both changing these guidelines and educating physicians on how to implement them. Most of us agree that in their current form they are unworkable and should be field tested before widespread use is expected. However, the next version of the guidelines, if used correctly by doctors, should help protect against unwarranted penalties from the Office of the Inspector General.

There are thousands and thousands of pages of rules and regulations, which are both cumbersome and complex, that we are obligated to become familiar with in order to comply with the federal government. Medicare alone has 45,000 pages of regulations – almost four times as many as the Internal Revenue Service! In fact, there may be so many laws and regulations that an offender might be hanged several times for the same offense.

Is society well-served by allowing an environment of criminalization to surround the doctor-patient relationship? I don't think we want a medical care system in which practitioners live in daily fear of an honest mistake potentially resulting in an assault from some government agency. Let's tell our federal legislators that honest mistakes that result from too many confusing and conflicting regulations are certainly not fraud.

GUEST EDITORIAL

MSAs and medicine's free market component

By Robert F. Hamilton, MD

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A crimonious criticism of the medical profession and outraged rebuttal have recently appeared in the press regarding physician fees, income and responsibility for current economic and functional problems in our nation's health care system. A free market component in this system would help to resolve these differences. The medical savings account is the ideal free market component.

In a free market system – one removed from arbitrary restrictions – patients, their physicians and hospitals negotiate services and price without outside manipulation or control. This does not mean going to the doctor or hospital becomes like negotiating a car's price. It does mean, however, that participants will be able to make mutually agreeable decisions based upon consultation and reason.

Unfortunately there is no free market component, nor has there been for more than 50 years.

Prior to the advent of health insurance, physicians charged what the market would bear: We paid in dollars or chickens, depending on economic times and geographic standards. Technology was embryonic and fairly inexpensive. After World War II, health insurance expanded rapidly, covering most of the working population. The federal tax code allowed employers to pay for employee health insurance with pre-tax dollars, whereas employees and the self-employed had to use after-tax dollars to buy the same insurance. Labor unions demanded and won first-dollar coverage until it became the norm – later to be modified by low deductible insurance with copayments. In addition, federal and state governments created Medicare and Medicaid. The system worked because times were good and technology was still young.

However, there was no real free market component to control costs. Everything was paid for with someone else's money. As technology increased and training periods lengthened, prices rose. Also, as people began to expect perfection, an ever-ready plaintiff's bar was waiting to add enormously to health care costs by creating the medical malpractice litigation industry.

Historically, physician fees have been responsible for less than 20 percent of health care costs. Yet, the law has made it virtually impossible for us to regulate that 20 percent. For the last two decades or more, federal anti-trust laws have prevented the adjudication – or even the discussion – of professional fees by any group in organized medicine, a frustrating situation for many peer review committees.

Most physicians tried to maintain fair and appropriate fee schedules and practice patterns, but fees were largely a matter of opinion. Physicians and hospitals provided what they felt patients needed without enough concern for cost. There were no financial con-

straints operating between the provider and the patient, except for those that were self-imposed.

In response to inevitable economic pressures, government, business and the insurance industry have drastically lowered Medicare payments and have created the present managed care system. Now these entities have tyrannical power over the lives of patients and the vitality of the health care professions, with little regard for patient health or for adequate compensation to the provider.

Today, large numbers of employees have little alternative but to join managed care plans. Physicians and hospitals are forced to participate in HMOs because of the large number of patients these plans control. Often neither patient nor provider participates by choice. Once again appropriate price and service are a matter of opinion – now strictly a reflection of the bottom line of the managed care entity. Once again there is no free market component.

The MSA is the only free market plan that would promote cost-consciousness, preserve patient choice and buffer the abuses of third-party payers. The difference in cost between low- and high-deductible insurance is placed into a tax-free account, which belongs to the patient and is used to pay for routine medical expenses. This encourages patients and providers to be prudent, without sacrificing either standards of care or professional ethics.

Grudgingly passed into law as part of the federal Health Insurance Portability and Accountability Act of 1996, and recently offered to Medicare recipients, MSAs have been so hamstrung by legal restrictions that they currently have little impact on health care. Insurance carriers, banks, and savings and loans have little incentive to fully develop MSA programs in such a restricted market. Public education about them has been inadequate, usually misleading and often deliberately misinforming.

Congress and the President should lift legal restrictions on medical savings accounts, such as the 750,000 enrollee cap for employees and the self-employed, the 390,000 enrollee cap for Medicare patients and the restriction of MSAs to companies with 50 employees or less. If MSAs enter the health care system free of artificial constraints, managed care and government care systems will adapt and change, simply because dissatisfied patients and providers will be free to choose a cost-efficient alternative.

A viable MSA component in the health care system is the very best way to allow the marketplace to determine what practice standards are optimal and what fees are appropriate. ■



Dr. Hamilton is an ISMS Sixth District trustee and an Alton general surgeon.

LETTERS

Some difficult patients' problems may run deeper

The useful article, "Working with difficult patients" in the Feb. 20 issue, deals with the legal issues surrounding a physician's responsibility for such difficulties as noncompliance with appointments and medications, having someone else present during an office visit, abusive behavior and unreasonable demands.

I know the article intended to look into the potential underlying clinical issues that might be contributing to these difficulties. At some future time, I think it would be useful to have a feature that looks beyond the troublesome patient behaviors to clinical conditions that might well be manifested by the behaviors and which could and should be addressed.

In workshops for physicians, I have outlined some of the possible patient behaviors which should alert non-psychiatric physicians to any of a number of psychiatric conditions that may not have been assessed or treated. Such difficult persons may have unrecognized attention deficit disorder, bipolar disorder, obsessive-compulsive disorder, depression, social phobia, substance abuse, dependent personality disorder, borderline personality disorder or other psychiatric disorders.

Impulsiveness, anger control difficulties, increased fearfulness, over preoccupation about health matters, overdependency and forgetfulness can all be manifestations of an underlying psychiatric problem or problems. In some cases, there is more than one psychiatric condition present. For instance, comorbidities such as attention deficit disorder, bipolar disorder and obsessive-compulsive disorder, sometimes complicated by borderline characteristics, give a pattern of difficult behaviors meriting thorough clinical assessment.

For most nonpsychiatric physicians, I know that thinking about these possibilities is not at the top of their index of suspicion list. Patterns or episodic appearances of such difficult patient behaviors should alert all physicians to such possibilities even if they do not intend to fully assess or treat any underlying psychiatric explanation for the problems.

Difficult behaviors should alert physicians not just to document well, but also to continue to think clinically and not to dismiss the behaviors as "bad choices." Consider them to be clinical indicators of possible medical-psychiatric problems instead.

Richard L. Grant, MD
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ISMIE Update

Coming soon:
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Good medicine, good advice: Avoiding medication mishaps

BY MINDY KOLOF

(Part 1 of a two-part series)

According to a recent report in USA Today, deaths from prescription drug errors increased at a higher rate over a 10-year period than any other cause of death except AIDS. In 1983, one of every 530 outpatient deaths was caused by medication errors; in 1993, the number was one in every 131 deaths – and still rising.

Proper medication procedure is critical to patient care. But it is an area fraught with questions whose answers are essential to not only your patients, but to the health and well-being of your practice as well.

What's the right way to handle samples, refills and product recalls? What are some of the legal consequences surrounding prescription errors? And, most importantly, how can medication mishaps be avoided in the first place?

SAMPLES: CAUTION ADVISED

Pharmaceutical company samples are easy to dispense and are an undeniable boon in terms of patient convenience. But, said Bill Rogers, an attorney with Bollinger, Ruberry & Garvey, samples must be handled by

physicians in the same way as all other medications.

Physicians must completely inform patients on all aspects of the medication, including what it treats, its benefits over other medications, its potential side effects and how to take it, Rogers said. "Be sure to stress that if side effects occur, the patient should call you or go to the emergency room."

He also urged physicians prescribing samples to document the fact in the patient's record. "If the medication proves to have side effects or is otherwise not right for the patient, it's helpful to be able to go back in the records and note that you discussed these possibilities before dispensing the drug."

Moline cardiologist Richard Snodgrass, MD, treats samples as a trial run for new medications. He tells his patients, "These samples are to make sure you tolerate the medication well before buying a month's worth." Once the samples are used without incident, only then is a prescription for the medication filled, he added.

Chicago pediatrician Jere Freidheim, MD, believes that samples can be more worry than they're worth. He uses

them very rarely. "It became too much trouble," he said. "Patients wouldn't take them correctly because the dosage wasn't indicated on the bottle."

Attorney Robert Smith of Lowis & Gellen in Chicago is even more cautious. "From a legal point of view, I'd be reluctant to give samples, particularly for drugs not approved for pediatric use," he said. He recommends physicians do their homework thoroughly before dispensing samples. "Ask the pharmaceutical sales rep for research and documentation on the medications and also request a supply of handouts for patients. Always make sure it's recent information, because the data changes over time."

REFILLS: LIMITING PROBLEMS

Prescription refills are another area where missteps can easily occur. Attorney Smith advised that "the safest method is to limit refills to just one. The more refills you have, the more danger that the dose has changed." For example, during a patient's hospitalization, her physician discovered a toxicity to a current heart medication, resulting in his decreasing the dosage prior to discharge. Unfortunately, when



Marc Burkhardt/SIS

the refill was called in several months later, it was for the higher, toxic dose.

Another sound piece of advice is to always check the patient's chart before approving a refill. "If you take a phone call from a pharmacist on a busy day, are you going to remember that you just filled a prescription for this patient two days ago? It's much safer to check the chart before giving the OK," Rogers said. This is especially true, he adds, if the drug in question is a narcotic, given the dangers of patient abuse, overuse and the potential to sell the medication.

In actual practice, many physicians appear to have prudent refill policies. Oak Park pediatrician Sharon Flint, MD, only refills prescriptions for patients she sees regularly; one-time medications and antibiotics require a patient visit. Dr. Snodgrass will refill for infrequently seen cardiology patients in emergencies only, but stipulates they must come in for a visit before any additional refills can be authorized.

Physicians should also make certain their office staff members understand their refill policies, such as what medications can be refilled without physician authorization.

RECALLS: GETTING THE WORD OUT

Medication recalls and alerts are rare enough events that

most physicians have no formal procedure in place to notify patients if one should occur. But perhaps they should, Rogers suggested. "A doctor's initial reaction might be to simply wait until the medication comes up for refill. But it's not the best course of action in a recall situation where physicians are already noticing a reaction to a particular drug. It's best to vigorously search the active patient files to identify people on the medication. It's a tremendous hassle, but there's a medical and ethical duty to alert people."

Smith noted: "The more serious the warning, the more persistent and thorough you need to be in your follow-up." But that's often easier said than done. Notifying patients would be problematic for most physicians' offices. Like most of the physicians interviewed, Dr. Flint doesn't have a way to easily distinguish who's on a given medication. "We'd have to brainstorm how to accomplish this," she said. "Perhaps post bulletins in the office as a start." But the keys once again are communication and documentation, which will go a long way toward reducing your liability. ■

(Part 2 will look at how to handle lost or stolen prescription pads.)

MALPRACTICE ROUNDUP

Jury awards \$15 million to stroke patient

Though the defense claimed that returning the patient to the operating room would have been too risky, a Philadelphia jury sided with her attorneys, who said that to do so would have substantially reversed neurological deficits brought on by a stroke occurring within hours of an initial surgery.

According to Dupon vs. Mildenberg, cited by the Feb. 9 issue of the National Law Journal, the patient was admitted for surgery to remove plaque from her left carotid artery. One of the risks of the procedure is an after-surgery stroke, because obstructions created during the surgery can cut off the flow of

blood to the brain. The patient suffered such a stroke, but she was not returned to the operating room.

The defense denied any negligence, citing the risk of additional surgery and said the stroke was caused by a shower of emboli at the brain, not because of an obstruction at the surgery site. The jury awarded the patient \$12 million and her husband \$3 million and apportioned liability of 70 percent to one of her physicians, 20 percent to the hospital, and 10 percent to her other physician. Post-trial motions are pending and delay damages could add another \$1.73 million to the judgment.

Escaping the Contract of Doom

Legal experts shed light on shadowy contract language where dangers can lurk.

BY LINDA MAE CARLSTONE



Fiona King

Navigating through insurance agreements these days can be as risky as Indiana Jones' venture into the Temple of Doom: If you don't know when to duck, the arrows could strike, the snakes could bite, or the financial floor could drop right out from under you.

"Contracts are getting much more threatening," said attorney Carol O'Brien, director of the American Medical Association's Division of Representation, which alerts physicians about abusive provisions and investigates contracts for language that may compromise patient care. It's no coincidence the print in managed care contracts is so small, O'Brien said she often tells physicians. "They don't want you to read them."

But small print glossed over at the time of signing will spring to

life in new and often dangerous ways when a looming controversy requires interpretation, clarification or resolution, she said.

To prepare for provisions that may later become legal quicksand, physicians must understand the legal implications of what they are signing, O'Brien said.

Chicago attorney Judee Gallagher warned that physicians should be leery of indemnification provisions where physicians assume liability for the plan. Sometimes the promise is very broad and reads something like: "The physician will indemnify and hold harmless the plan from and against any liability arising under the contract." Under this indemnification, if the physician and plan were both defendants in a lawsuit alleging negligence in rendering of any

(Continued on page 10)

Decoding contract booby traps

Warning! Some sample language from managed care contracts to look out for.

Legal experts explain the underlying meaning – and reveal why it's a trap.

Gag clause in disguise:

During the term of this agreement, provider and its qualified physician shall not advise or counsel an enrollee to disenroll from company's plan, and will not directly or indirectly solicit any enrollee to enroll in any other health care service plan or insurance program.

"No matter how it is dressed up, provisions that prohibit physicians from speaking freely with their patients chill the physician-patient relationship and are considered by many reasonable physicians to be a form of a gag clause," said attorney Mark Rust of the Chicago law firm of Barnes & Thornburg.

Action limited:

No action, regardless of form, arising out of or relating to this agreement may be brought by provider more than 12 months after such cause of action has arisen.

"The statute of limitations for actions on contracts vary from state to state but generally extend for five years," Rust said. "There's no rational reason why a managed care company should seek special treatment not available to others in limiting such actions to 12 months."

Hold harmless:

If the applicable payor is an HMO, provider hereby agrees that in no event, including but not limited to, nonpayment by the HMO, insolvency of the HMO or breach of this agreement, shall provider bill, charge, collect a deposit from, seek remuneration or reimbursement for, or have any recourse against, including, without limitation, the institution of any action at law, a member or persons (other than the HMO) acting on a member's behalf for covered services or any other amount owed provider by HMO.

"This means the physician must hold the plan harmless and continue to care for patients free of charge if it goes bankrupt," said Carol O'Brien, director of the American Medical Association's Division of Representation. "The physician agrees that if the plan becomes insolvent, he or she will not sue the plan or the patient for unpaid fees."

"It may be reasonable for physicians to sign a continuity of care clause, to care for patients for a specified length of time in the event of an insolvency – perhaps 60 days – and not collect from patients," she said. "But the plan should arrange for alternative care or agree to purchase stop loss insurance so there isn't a payment problem."

Indemnification:

Physician acknowledges that all patient care and related decisions are the sole responsibility of physician and that HMO's medical management procedures, protocols and policies do not dictate or control physician's clinical decisions with respect to medical care or treatment of members. Physician agrees to indemnify and hold harmless HMO from all claims, liabilities or other causes of action (including costs and attorney fees) related to physician's delivery of care and treatment to members.

An indemnification provision is a promise to assume your contractor's liability in particular circumstances, said Chicago attorney Judee Gallagher. The first sentence of this clause is implied indemnification because the physician agrees to be responsible for patient care decisions, which in many cases are made by HMO medical managers. Indemnification in the second sentence is directly stated.

All patients accepted:

Physicians shall accept all members who wish to become physician's patients, unless and until physician provides the plan with 90 days advance written notice that physician is not reasonably able to accept additional members as patients. ... The plan's acceptance of any such notification may be withheld as long as necessary for the plan to establish satisfactory alternative provider arrangements.

"At first blush, this might look like a patient protection clause to ensure that needy patients aren't turned away," the AMA's Carol O'Brien said. But look more closely and this is forcing the patient and physician together, she pointed out. The contract language offers physicians an opportunity to decline the patient by sending a notice to the plan; however, the plan reserves the right not to accept that notice.

"A physician must be free to choose patients according to the physician's competency level. Physicians should not be obligated to treat a patient if they are not comfortable treating the patient's illness, or if a physician's case load doesn't have room," she said.

Escaping

(Continued from page 8)

service under the contract, the physician could be responsible for paying the plan's defense costs, as well as any judgment against the plan, she said.

The scariest provisions, according to Mark Rust, attorney at the Chicago law firm of Barnes & Thornburg, fall under the category of "just plain unnecessary." An example of that, he said, is contract language that requires physicians to waive their right to damages other than

actual if they choose to sue the health plan. The clause further states that actual damages will be limited to total revenue received from the plan in the previous year. It effectively cancels most lawsuits a physician would bring against the company because the cost to litigate the case would be more than the one-year revenue limit, Rust said.

"Why do we even need that?" asked Rust, who drafted the AMA Model Medical Services Agreement. "The contract is supposed to set out the terms between a party receiving a service and

the party that will pay for the service."

Another problem provision, Rust said, is one in which the provider agrees to authorize the company to deduct money that may otherwise be due and payable to the provider from any outstanding moneys that the provider may, for any reason, owe to the company. "This provision gives the managed care company a free hand to deduct money from a physician or physician group without explanation," Rust said.

Physicians are wise to have an attorney review contracts before they sign them. But, according to O'Brien, some managed care contracts try to squelch that opportunity by including language such as "providers shall keep the proprietary information and this agreement strictly confidential and shall not disclose any proprietary information or the contents of this agreement to any third party. ..."

Some plans flat-out refuse to negotiate, offering a take-it-or-leave-it stance, O'Brien said. That point is written into one plan's contract with the words: A provider who objects to an amendment to this agreement may be removed from the panel with 10 days written notice.

"That's a chilling provision," O'Brien said. "A physician who attempts to renegotiate could be risking termination. To gauge their risk, physicians should consider the company's reputation and the physician's relationship with the plan. If a plan is difficult to deal with and has a history of punitive behavior," that's a good indication they will not be amenable to contract changes, O'Brien said.

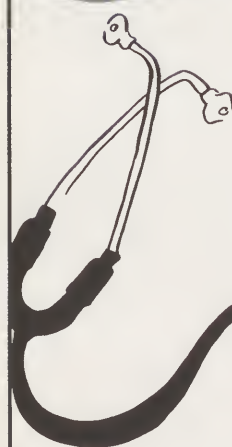
With plans open to negotiation, physicians can strike troubling terms and insert more balanced language, O'Brien stated. The AMA will help physicians modify language, she said. Changes should be initialed and signatures should include the words "as amended." It is not legal to simply cross out provisions without giving notice to the plan, she said. "There has to be a meeting of the minds or mutual agreement."

Sometimes the most offensive thing about a contract is what it doesn't say, according to both Rust and O'Brien. Many contracts fail to clearly state the covered services and what the payments will be. Instead, they use vague language stating the physician will be paid according to the plan's fee schedule, which is subject to change by the plan's sole and unilateral discretion. "This means we can pay you what we want," Rust said.

O'Brien said that physicians don't need to face the perils of shadowy managed care language on their own. She suggests they take advantage of the force and power of organized medicine.

"The collective weight of ISMS and the AMA may have more clout than a lone physician," O'Brien said. "The AMA will send the plan a letter on the record raising our concerns. Often, these issues will generate patient outcry and be picked up in the media, which aids in persuading them to change," O'Brien concluded, indicating that there is a light at the end of the tunnel, indeed an escape from the Contract of Doom. ■

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November 1997

Gordon Shaw, Ottawa – physician and surgeon license indefinitely suspended and controlled substance license revoked for gross negligence, nontherapeutic prescribing of controlled substances, unprofessional and immoral conduct.

Jawed Siddiqui, West Frankfort – physician and surgeon license suspended for six months followed by probation for one year for allowing another person to use his license to practice medicine and aiding and abetting an unlicensed person in the practice of medicine.

Allen Tybor, Chicago – physician and surgeon license reprimanded for failing to accurately notify his patient of the results of an MRI.

Calvin Williams, Chicago – physician and surgeon license reprimanded for violating the terms and conditions of a previously ordered Department probation.

December 1997

James R. Adams, Evergreen Park – physician and surgeon license reprimanded and fined \$500 for unintentionally participating in a bait and switch operation conducted by a previous employer, and allegedly failing to adequately track excessive charges billed under his signature.

Roberto Adan, Woodridge – physician and surgeon and controlled substance licenses revoked for prescribing medications without therapeutic reason, breaching responsibility to his patients, and causing harm to patients by potentially fostering drug dependency.

Ala Albazzaz, Bloomingdale – physician and surgeon license indefinitely suspended and fined \$30,000 for fondling female patients during examinations.

Luis Bacayo, Ransom – physician and surgeon license indefinitely suspended followed by probation for one year for fondling a male patient during a prostate examination.

George E. Bryar, Palos Heights – physician and surgeon license revoked for being more than 30 days delinquent in the payment of child support.

Kuo-Tung Cheng, also known as Kenneth K.T. Cheng, Rock Island – physician and surgeon license reprimanded for failure to report the revocation of his staff privileges at his place of employment.

Charles William Cooper, Frankfort – physician and surgeon license placed on indefinite probation for violating the terms and conditions of a previously ordered Department probation.

Facundo Dovale, Berwyn – physician and surgeon and controlled substance licenses placed on indefinite probation due to substance abuse problems.

Nancy Field, Palos Park – temporary physician and surgeon license issued on probation for its duration due to substance abuse problems.

Ronald James Grason, Chicago – physician and surgeon license placed on indefinite probation due to outstanding tax liability owed the Illinois Department of Revenue.

Saeed Khan, Benton – controlled substance license placed on probation for one year for failing to keep a proper controlled substance log and inventory records.

Maria Kraszynska, Prospect Heights – controlled substance license reprimanded for practicing on a nonrenewed license.

Distadado Momongan, Northbrook – physician and surgeon license suspended

for 75 days followed by probation for three years for making repeated unprofessional sexual remarks to one patient and repeated unprofessional sexual and racial remarks to another patient.

James R. Nikoleit, Lombard – physician and surgeon license placed on probation for two years and fined \$1,000 for exceeding the scope of the practice of internal medicine in his treatment of a patient and allegedly failing to grant his patient's request for an appropriate referral.

Jeremiah Park, Evanston – controlled substance license reprimanded for prescribing a Schedule II controlled substance to one

patient on a nontriplicate prescription form for a prescription filled in the state of Wisconsin, which does not have a triplicate prescription reporting system.

John Kevin Paulsen, Peoria – physician and surgeon license placed on probation for two years for performing elective surgery on a hernia patient who was at risk and later died, constituting gross negligence.

Edward Yavitz, Rockford – physician and surgeon license reprimanded and fined \$300 for advertising that he had the only argon krypton laser in his area outside a hospital setting.

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Family physicians needed for small towns in rural Iowa. Contact Jerry Hess, Mercy Family Care Network, 1000 Fourth St. SW, Mason City, IA 50401. Call (888) 877-5551 or fax (515) 422-6388.

Family practice, Eau Claire, Wis. – Marshfield Clinic, a 500-physician group is seeking a seventh family physician for its clinic in Eau Claire, near Minneapolis. University town, teaching available. Call (800) 611-2777 or fax (414) 784-0727.

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Physician-friendly

(Continued from page 1)

Also, in the race to replace retiring state Rep. Verna Clayton (R-Buffalo Grove), physician-friendly Sidney Mathias, the current president of the



Krause

Village of Buffalo Grove, defeated three challengers for the Republican nomination. More than 200 physicians in the district received IMPAC letters asking them to support Mathias. One challenger was Long Grove resident Mike

Salvi, the brother of Al Salvi, who won the Republican secretary of state nomination, and Pat Salvi, former president of the Illinois Trial Lawyers Association.

In light of the Illinois Supreme Court's recent decision to strike down the 1995 tort reforms, IMPAC has increased its attention on judicial elections, particularly open seats on the state's appellate courts.

Every vote counted in the Republican primary for the Fourth District Appellate Court, covering 30 central Illinois counties. IMPAC mailed over 1,800 letters to physicians in the Fourth District in support of Thomas Appleton, a sitting Sangamon County Circuit Court judge with over 20 years of legal experience. Appleton won the Republican nomination by less than 100 votes, according to unofficial election results.

Two seats are open on the First District Appellate Court, which encompasses Cook County. Kenneth Gillis, the Cook County Circuit Court judge who ruled the entire 1995 tort reform law unconstitutional, lost the Democratic nomination for one of those appellate court seats to Margaret McBride. The Democratic nomination for the other seat went to Michael Gallagher, a former defense attorney who represented physicians.



Gallagher

Downstate U.S. Rep. Glenn Poshard emerged the winner in a hotly contested Democratic primary for governor. He now faces current Secretary of State George Ryan, who beat a nominal primary challenger to win the Republican nomination for governor.

Physician presence in Washington may increase if two Illinois physicians who won Republican nominations defeat incumbent Democratic U.S. Representatives this November. William



Dr. Price

Price, MD, a Belleville orthopedic surgeon and the son of former U.S. Rep. Melvin Price, won the Republican nomination for a Downstate district. He now faces U.S. Rep. Jerry Costello (D-Ill.). Also, Burr Ridge radiologist Robert

Marshall, MD, faces U.S. Rep. William Lipinski (D-Ill.) in November.

Republican and Democratic candidates will face off against each other in the November general election, when many additional races across the state will impact physicians. Dr. Freidheim

said, "Physicians need to stay active and involved in the election process so we can continue to ensure that physician-friendly candidates remain or become elected officials."

Voters also expressed support for managed care reforms by overwhelmingly approving two referendums that asked if Illinois should enact the Managed Care Reform Act. In Cook County, the referendum was passed 480,484 to 41,894, while the Lake County town of North Chicago approved a similar proposal 886 to 195. Both referendums are nonbinding. ■

ISMS ALLIANCE President Julie Ringhofer (left) and St. Clair County Alliance President Julie Chadwick accept an award from Carol Bartle of the Women's Crisis Center in Belleville Feb. 28 for the alliances' work with the center.



Maureen Houston

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CHIP

(Continued from page 1)

least 500 people had joined the plan by the time CHIP held the news conference, and Carlson said he hoped additional publicity would encourage more Illinoisans to take advantage of it.



Andrew Corrigan Halpern

DR. ORŁOWSKI, a CHIP board member and an ISMS Third District trustee, fields questions regarding the program's new, no-waiting-period insurance plan.

"This is an important and dramatic change in the insurance market in the state of Illinois," added Janis Orłowski, MD, a CHIP board member and an ISMS Third District trustee. "This increases the quality of life. It allows these individuals to have mainstream opportunity and allows them to remain with the physicians and the hospitals where they're currently receiving treatment for their pre-existing illnesses."

In order to qualify for CHIP's new product, an Illinois resident must be a "federally eligible individual" as defined in HIPAA. To become and remain federally eligible in the individual market, residents must have no other group coverage or Medicare or Medicaid coverage and must first exhaust any COBRA coverage. They must also accumulate at least 18 months of credible health insurance coverage without a 62-day break.

Although CHIP's new plan will accept anyone who is federally eligible, individuals may want to try to get insurance with lower premiums from other insurers, Carlson said. "Our recommendation is that they go ahead and apply to CHIP and get in, so they don't lose that 62-day period and take the risk of losing their eligibility for this insurance program. Then, if they find out from a private insurer that they have coverage without a waiting period, they can drop CHIP."

Premiums for the CHIP's new plan are set in statute, Carlson explained.

Currently, an individual policy will cost about \$330 a month, which is similar to the premiums for other CHIP plans. Insureds' premiums will only cover about half of their annual costs. To pick up the program's resulting deficit, CHIP has created a fund with \$7.5 million collected from Illinois insurance companies, Carlson said.

Insurance companies agreed to pay the assessment, Dr. Orłowski explained, as part of an agreement to implement HIPAA using a statewide "acceptable alternative mechanism," which is CHIP's new insurance product. The state's other implementation option would have required all Illinois insurers to guarantee coverage without pre-existing condition exclusions or waiting periods. Dr. Orłowski said, "My understanding from the insurers is that this [alternative mechanism] levels the playing field because one company doesn't get all the higher-risk [patients]."

The CHIP board estimates about \$30 million will be needed to maintain the plan, Dr. Orłowski said. It will revisit the premiums and insurance company assessments once it has more experience administering the plan.

Once accepted, an individual like Gardner can remain in CHIP's plan as long as he or she remains eligible, Carlson said. "If you become eligible for other insurance like, for instance, if Amy were to go work for another employer that offers health insurance, then she becomes ineligible for CHIP and she has to go on that private employer's plan," Carlson explained. "That new private group would not be able to apply a new waiting period. The time she's in CHIP will count toward any waiting period."

For more information about CHIP's new insurance product, call (800) 962-8384 or write to CHIP at 400 W. Monroe St., Suite 202, Springfield, IL 62704. ■

OMSS

(Continued from page 1)

unions, deciding to form an independent group, Dr. Norem said.

Organizers see collective bargaining as a way for physicians to gain input into the system that often fails to listen to their concerns, Dr. Norem said. Critics say it creates another bureaucracy and leads to a loss of professionalism, he said.

Attorney Carol O'Brien, director of the American Medical Association Division of Representation, which was formed to provide aggressive advocacy to members on health plan policies and contracting issues, said that the AMA has been working for several months with the Rockford physicians seeking collective bargaining. Together they persuaded the National Labor Relations Board to issue an unfair labor practice complaint against the RMHSC.

The jury, however, is still out on the fate of the Rockford Physicians' Council's efforts to form a collective bargaining unit, Dr. Norem said. The RPC has filed a petition with the NLRB to hold an election seeking to collectively bargain with its employer. It currently awaits an NLRB decision on which doctors are eligible to vote in the election.

Physician interest in forming unions has heightened in recent years, O'Brien said. But unionization is not an option for all physicians, she added. The laws affecting forming unions and the activities unions are allowed to engage in for physicians are complex, she said.

"We hear from independent physicians asking, 'Why can't we form a union?' Under anti-trust laws, independent physicians are competitors and cannot engage in collective bargaining as a group," she said.

"That distinction is important and the unions have been unclear about what you can and cannot do," O'Brien said. "No surprise, unions see physicians as a ripe market and are actively marketing their business."

O'Brien also told physicians assembled

for the OMSS meeting not to throw in the towel. There are many avenues where the AMA and ISMS can work with physicians to resolve or prevent abusive treatment by health plans. For example, medical societies can engage in dialogue with health plans on clinical, noneconomic issues to modify contracts. The AMA has written letters to health

plans addressing contract concerns. This technique is the beginning of a dialogue, O'Brien said. "We can't force them to sit down at the table the way a union can, but we can apply a great deal of pressure."

The AMA recently unveiled a model contract that can be used by physicians and their legal counsels as a template to compare with contracts

they are reviewing. The model contract is also an effective tool for public policy-makers to use in shaping legislation, she said. The AMA received more than 400 physician requests for assistance in a three-month period, November through January, and more than 500 requests for the model contract.

Medical societies also lobby health plans in the public sector, working together for laws that protect the rights of patients and physicians. In addition, medical societies can assist employed and resident physicians in negotiations on employment issues. ■



Brian Waring

O'Brien

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"Why are we losing
so many doctors?"
a town asks

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Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • APRIL 17 1998

ISMS'
anti-smoking
stance affects
public policy

PAGE 2

Medical Society to state: Keep immunization requirements intact

DEBATE: Critics shoot for voluntary vaccine system. BY LINDA MAE CARLSTONE

[SPRINGFIELD] In a hearing punctuated by emotional testimony challenging Illinois' immunization requirements, ISMS President Jane Jackman, MD, called on the state to hold in place its current

vaccine standards for school children.

"Required immunization against communicable disease is good public health policy," Dr. Jackman testified at the public hearing held March 26

in Springfield. "It prevents suffering and saves lives."

Dr. Jackman's comments came at the last in a series of four hearings held since Oct. 24 by the Illinois State Board of Health to solicit public input on Illinois childhood immunization requirements.

On the opposing side of the matter are some parents and groups concerned with the health risks posed by adverse immunization reactions. Dr. Jackman expressed sympathy for these parents. "No parent can be blamed for being concerned that their child could be the case that happens less than one in a million times," she said. "But weakening our resolve will result in many more than one of every million children getting sick."

Thomas Herr, MD, president of the Illinois Chapter of the American Academy of Pediatrics agreed that the good of many

(Continued on page 14)



ISMS PRESIDENT JANE JACKMAN, MD, tells the Illinois State Board of Health that weakened immunization requirements would lead to more children getting sick.

Nurses' bill passes Senate

[SPRINGFIELD] As this issue of Illinois Medicine went to press, the Illinois Senate passed 58-0 an interim-agreed bill that would license nurse practitioners, clinical nurse specialists and nurse midwives in Illinois.

It contains no provisions related to certified registered nurse anesthetists because those provisions remain to be worked out as the House of Representatives considers the bill. Sen. Doris Karpel (R-Roselle) served as lead sponsor of the bill.

Watch the next issue of Illinois Medicine for details and an analysis of S.B. 1585.

Patient rights bills churn through the Legislature

OUTLOOK: Hope springs eternal that lawmakers won't wait until next year. BY LINDA MAE CARLSTONE

[SPRINGFIELD] The chances to reform managed care remain alive in Illinois this year as the General Assembly plays hot potato with patient rights plans now stewing in the Legislature.

ISMS has called on its members to lobby their legislators to back S.B. 1666, a Society endorsed bill that targets basic rights for patients with respect to quality, choice, individual respect, advocacy and information.

"We need to remind our legislators that managed care abuses are becoming a major problem for the people they

represent," said ISMS President Jane Jackman, MD. "Eighty-five percent of employed people get their health insurance from managed care. The time is right to pass a comprehensive bill."

Key components of the bill would bar gag clauses, provide a method to resolve grievances and assure timely access to primary care and specialty physicians of a patient's choice.

What, if any, patient rights bill will land in the governor's lap when the Legislature adjourns later this spring is still up for grabs. The House

(Continued on page 10)

Hastert to speak at ISMS public affairs breakfast

[OAK BROOK] U.S. Rep. J. Dennis Hastert (R-Ill.), chairman of the Working Group on Health Care Quality, the group responsible for reviewing bills on health reforms and patient rights, will address physicians at this year's ISMS public affairs breakfast at 7 a.m. on April 25.

The House's chief deputy majority whip and a friend of medicine, he will discuss physicians' prospects in the

(Continued on page 13)



David Hathcock

Hastert

Resolution count tops 100 for first time in a generation

ANNUAL MEETING: Delegates to debate health care climate. BY LINDA MAE CARLSTONE

[OAK BROOK] ISMS delegates will converge in Oak Brook later this month to debate solutions to some of today's toughest health care problems, including managed care, burdensome government regulations and hospital medical staffs. Their outpouring of concern is reflected in the highest number of first-deadline resolutions submitted in a generation.

The 1998 House of Delegates will meet April 24-26 at the Oak Brook Hills Hotel. There were 106 resolutions placed on its agenda by the March 23 submission deadline – by any measure a nearly overwhelming response – more than for any other annual meeting in the past two decades.

The last time the first-deadline resolution count exceeded 100 was in 1977, when 106 resolutions were also submitted.

The annual meeting is a chance for delegates to bring their issues and concerns about preserving quality health care to the Medical Society, said Speaker of the House John

Schneider, MD. Resolutions are fully discussed and debated with final recommendations approved by the majority, he explained. Decisions can lead to policy set by the Medical Society, lay the groundwork for further study, and also influence the Society's legislative agenda.

Objections to pending evaluation and management guidelines to document physicians' services for Medicare payments

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Medical staffs
need to remain
active

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Anti-smoking stance impacts public policy, attitudes

PROGRESS: Smoke-free society no longer a pipe dream. BY LINDA MAE CARLSTONE

[CHICAGO] It's been almost 20 years since the ISMS House of Delegates passed its first resolution aimed at snuffing out cigarette smoking and its accompanying illnesses. Back then—in 1979—cigarette smoke billowed from most corners of public domain: office cubicles, hospital waiting rooms, trains, airplanes and hotels. The entire restaurant, not just a back nook, was a smoking section.

Now, two decades and 13 resolutions later, smoking is shunned in most public places, evidence that ISMS and other antismoking advocates have made an impact. "Considering where we've come from, there has been much headway," said ISMS President Jane Jackman, MD. "Just look at the many establishments that are not smoke-filled anymore."

While one might have liked for the ultimate goal of a nonsmoking society to happen overnight, Dr. Jackman said ISMS has always taken a more realistic approach. "We're trying to chip away at these one by one," she said.

Certainly, there have been victories. The state cigarette tax has been hiked several times over the years, moves consistently supported by ISMS. The per-pack tax on cigarettes, which began at 12 cents in 1941, increased to 20 cents in 1985, 30 cents in 1989, 44 cents in 1993, and 58 cents last year, where it currently stands. The American Cancer Society has noted that every 10 percent increase in the price of cigarettes translates to a 10 percent decrease in teen smoking.

As directed in a 1996 resolution, the Society threw its muscle behind Illinois' participation in a 40-state lawsuit against tobacco companies. The suit—which is now being litigated on a state-by-state basis—seeks to force tobacco companies to pay Medicaid and other state health care costs for illnesses that are smoking-related. Illinois has incurred more than \$2 billion in such costs since 1980, according to Illinois Attorney General Jim Ryan.

"As you pursue this litigation ... we will support you in efforts to rid society of the health risks and inappropriate costs of smoking," ISMS Board of Trustees Chairman M. LeRoy Sprang, MD, vowed in a September 1996 letter to the attorney general.

Proposals for a national tobacco settlement to resolve the state suits are pending in Congress. Illinois' part of the suit is still about one year from trial, said a spokesperson for the attorney general's office.

*"Considering
where we've come
from, there has been
much headway. Just
look at the many
establishments that are
not smoke-filled
anymore."*

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for
you**

ISMS also backed a drive to financially slap tobacco companies. A 1997 resolution directed the Society to participate in a movement to sway faculty stockholders in a teacher retirement fund to divest of tobacco investments. Dr. Sprang asked faculty leaders at eight Illinois medical schools for help in rallying support for a resolution on the stockholders' proxy ballot calling for tobacco-related investments to cease.

The resolution failed to pass last fall, and supporters are in the process of examining what tack to take next.

Much of ISMS's anti-smoking efforts have been waged on the legislative front. That first ISMS anti-smoking resolution approved in 1979 directed the Society to support and encourage legislation to ban all cigarette advertisements and to encourage anti-smoking campaigns in the media.

Several resolutions adopted from 1988 to 1996 call for the Society to seek smoking bans in physicians' offices, public health facilities, hospitals and other public places, specifically in restaurants, stadiums and on public transportation. With varying success, the Society has actively supported legislation and regulatory changes over the past 10 years to eradicate smoking in public. A 1989 law restricted smoking to designated sections in enclosed indoor areas used by the public or

serving as a place of work.

It was strongly opposed by restaurants in addition to the tobacco lobby. ISMS has surveyed legislators on the issue and found that the vast majority think the bill goes too far.

Illinois passed a law in 1987 that billboard advertisements for smokeless tobacco shall carry a health warning.

There have been some legislative inroads to block children from cigarettes. An anti-smoking law passed in 1993 prevents children's access to tobacco products by authorizing state inspections of retail tobacco distributors and by levying fines for violators.

A 1994 resolution directed the Society to support legislation that would prohibit the possession of tobacco products by minors. One proposal, to prohibit minors from buying or possessing tobacco, was recently approved by the House Judiciary II-Criminal Law Committee. Currently, the law prohibits children from buying cigarettes, not possessing them.

Dr. Jackman said that efforts to discourage teen smoking have apparently fallen short, however, with statistics showing the number of teens who smoke rising. An Illinois Department of Human Services study on the percentage of youth in grades 8-12 who smoked tobacco showed a steady increase from 1990 through 1995.

Dr. Jackman said the Society should give top priority to supporting anti-smoking campaigns that reach young people. It should also continue education efforts on the health risks from smoking, as well as continue to pursue legislation designating more facilities as nonsmoking. "Obviously tobacco speaks loud and long," Dr. Jackman said. "We need to keep plugging away."

Medicaid will cover telemedicine expenses

[SPRINGFIELD] Medicaid has expanded its coverage to allow patients to receive health care via telemedicine, Gov. Jim Edgar announced. The state will also pay telemedicine claims for outpatient services provided after Jan. 1, 1998.

"The addition of telemedicine to the Medicaid program will help low-income patients connect with more specialty health services, and it eliminates the need for many persons in rural areas to travel long distances for emergency or specialty care," Edgar said.

For emergency room visits, Medicaid will reimburse both the hospital and the medical specialist or consultant who appears on the video link at another location. For nonemergency cases, the patient's attending physician must request a telemedicine consultation, and the request must be documented in the patient's medical record.

Fewer than a dozen states currently pay for services provided through telemedicine, including Arkansas, California, Georgia, Iowa, Kansas, Virginia and West Virginia. Private health plans in Illinois do not offer telemedicine coverage.

The ISMS Committee on Health Care Access met with the Illinois Department of Public Aid to discuss the effect of telemedicine on Medicaid care.

"We hope that the Medicaid decision will spur private health insurance plans to cover telemedicine expenses," said John Lumpkin, MD, director of the Illinois Department of Public Health. "Patients' ability to reach care through telemedicine can diminish the need for patient travel, improve care in local settings and encourage more efficient use of all health care resources."

Medicaid developed its policy on telemedicine with help from the 13 physicians who serve on the State Medicaid Advisory Committee, said IDPA Director Joan Walters.

Porter honored for support of cancer research

[SAN DIEGO] U.S. Rep. John Porter (R-Ill.) received the 1998 James Ewing Layman's Award March 28 at the Annual Cancer Symposium of the Society of Surgical Oncology in San Diego, Calif. The award is presented annually to a nonphysician who has made significant contributions to improving the care of cancer patients.

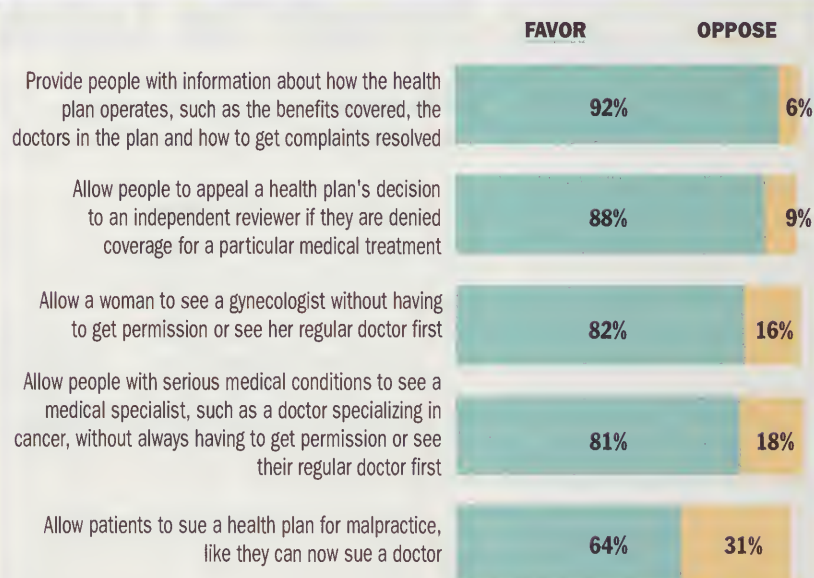
A strong supporter of the Centers for Disease Control and the National

Institutes of Health, Porter has helped increase NIH funding and limit the impact of politics in research decision-making. This funding is vital to cancer research, according to the surgical society.

Porter is also chairman of the U.S. House Labor, Health and Human Services Subcommittee. He launched an initiative to raise NIH funding in 1995 while other congressional committees were proposing deep budget cuts.

AMERICANS WANT CONSUMER PROTECTIONS

Percent of Americans who say they would favor a law requiring health plans to...



NOTE: "Don't Know" not shown.

SOURCE: Kaiser/Harvard National Survey of American's Views on Managed Care, 1997.

Courts' ruling blurs medical assistant role

IMPACT: Questions raise note of caution. BY LINDA MAE CARLSTONE

[WHEATON] Can a medical assistant who crosses the territorial line into nursing duties be in violation of the law?

The DuPage County Circuit Court and an Illinois appellate court recently answered yes to that question in the case of *People vs. Nanette Stults*, a medical assistant found guilty of practicing nursing without a license. Although the ruling dealt with one medical assistant in one office, the case sounds a note of caution to all physicians who use medical assistants, said ISMS General Counsel Saul Morse.

The trial court stated in its decision that evidence was clear Stults performed duties that are restricted to a nurse, particularly administering injections and immunizations. Although the court believed Stults had the ability and qualifications to perform the tasks she performed, it stated that Illinois law required her to be licensed regarding those tasks. She was sentenced to one year of supervision, a fine of \$250, and 60 hours of public service employment.

The charge against Stults related to her job in a pediatric practice, where, according to her testimony, her duties included giving nutrition advice over the telephone; administering injections, finger-stick blood drawing and respiratory treatments; and removing umbilical cords. Stults argued that as a medical assistant working under the supervision of a physician she was permitted to perform those functions.

Stults appealed to the Second District Appellate Court, which upheld the decision. The court pointed out in its decision that there is no reference in Illinois law to the qualifications of medical assistants, so the Legislature is presumed not to authorize them to perform any task clearly within the domain of a licensed individual.

The American Association of Medical Assistants, which applies a broad definition to the position, estimates the number of people employed as medical assistants at nearly one million, according to Donald Balasa, executive director and legal counsel of the 20,000-member organization.

The case's impact on the many Illinois physicians' offices employing medical assistants will vary depending on the duties the assistants perform, Morse said. Scheduling and billing are clearly tasks medical assistants are permitted to do. However, duties such as injections, taking medical histories and blood pressure are gray areas, he said.

ISMS policy regarding medical

assistant licensure is that physicians should be able to hire people to assist in the office, and to train and supervise them without needing them to be among the current classes of licensed individuals, Morse said. The warning for physicians from this case is that while they may be able to employ unlicensed individuals to provide some assistance, there is risk in permitting them to perform functions generally recognized to be within the

professional domain of nurses, Morse said. If the office employs nurses as well as medical assistants, then a physician should "lean toward the nurse to do jobs such as injections." He added that the distinctions between other assignments permitted medical assistants and nurses, depending on their degree of difficulty, are blurred.

Circumstances particular to this case make it less likely to be applicable to most physicians' offices," Morse said. "There was conflicting testimony as to whether the defendant ever misled her employer to believe she was a registered nurse." Some of her employers said they

believed or assumed she was a nurse; Stults denied ever telling her employer she was a registered nurse.

In some ways the case raises more questions than it answers, said Morse. Since the case was brought against the employee, the risk to physicians is indirect. However, negligent supervision of a medical assistant, or improper assignment of duties to a medical assistant could come up in a malpractice case, he said. Physicians should be careful what duties they assign medical assistants, supervise them very closely, and stay tuned to further rulings affected by this case, he concluded. ■



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Specific Care-Value Pathways will be published in subsequent issues. Comments and suggestions for annual revision can be directed to Prentiss Taylor, MD, Medical Director, Care Management, at 300 E. Randolph, 24th Floor, Chicago, Illinois, 60601.

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EDITORIAL

HIV name reporting

Recently, the Illinois Department of Public Health announced a proposal that would require physicians to report the names of patients who test positive for HIV. This proposal, which could go into effect as early as late spring or early this summer, would provide the state with an additional tool to track trends in the spread of this infection and to develop the appropriate means of combatting it.

ISMS applauds the state's idea, because it is consistent with a position taken by the ISMS House of Delegates in 1994. ISMS believes that HIV should be treated like any other infectious disease and state public health officials must have this information available to track infection trends and respond accordingly.

IDPH's proposal is also consistent with the state's own policy for disease reporting – IDPH now requires name reporting for at least 60 infectious diseases, including tuberculosis, gonorrhea, syphilis and AIDS itself. As IDPH Director John Lumpkin, MD, has said, disease prevention is a medical problem that needs to be treated through proven public health solutions, despite the social stigma attached to name-reporting this particular virus.

Critics of the plan have argued that the belief that the names of those who test positive for the virus would be inappropriately distributed is reason enough to discourage individuals from

seeking HIV testing in the first place. A report from the CDC, which has urged Illinois to adopt such a policy, suggested that argument doesn't hold water, showing that a mere 1.4 percent of all HIV-positive individuals delayed being tested because of the reporting systems in place in their states. It is also important to note that since Illinois began collecting the names of individuals with AIDS in 1981, there have been no breaches in confidentiality during the reporting process.

Unlike the reporting protocols for most infectious diseases, Illinois physicians would use a "unique identifier" assigned to each HIV-infected patient to show the patient's demographics. The identifiers would allow the state to track trends in the spread of the disease without using the individuals' real names.

IDPH has scheduled public hearings about HIV name reporting for April 27 and May 4. The state agency will submit the comments it receives to the General Assembly's Joint Committee on Administrative Rules, a panel that must approve the proposal before it can go into effect. That committee will then offer a 45-day comment period before making its final decision.

Mandatory HIV reporting is a wise and prudent move on behalf of the IDPH. Physicians should make their opinions known about this proposal during the public hearings.

PRESIDENT'S LETTER

In praise of 'thoughtful, committed' physicians

Jane L. Jackman, MD



"So many of you still find time to reach out to those in need."

During the past year, I have been privileged to travel around the state meeting with many of you, our members, in your hometowns. It has truly been one of the most enriching experiences of my career to be your president and to represent your views to the world outside of medicine. Whether discussing the need for managed care patient rights legislation, advocating more compassionate care for the terminally ill, or discussing the relevance of lawsuit reform to the cost and accessibility of health care in Illinois, the badge of office you entrusted to me has given me the courage to speak out on behalf of our patients.

In my travels, I have seen firsthand how each of you helps shape public opinion favorably toward the concerns of organized medicine. This happens because of the trust you build with your patients every day. That trust is much like a plot of land. If we nurture it in every individual patient encounter, the messages we pass along through the media and other means will be sown on it like seeds to grow. However, if we neglect it, our messages cannot take root and survive. Ultimately, the success of any ISMS endeavor relies on the good will you engender with your patients and the good works you do in your local communities.

I have found it heartwarming that despite the considerable stress and frustration many physicians currently experience in this new era of managed care, so many of you still find time to reach out to those in need. Professionalism, a caring spirit and a desire to do your best for your patients and the health of your communities are alive and well in every county medical society in Illinois.

Anthropologist Margaret Mead said, "Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed it is the only thing that ever has." I have met so many

"thoughtful, committed" doctors this year on my president's tour, but here are a few of the highlights:

- Doctors actively involved in our 23 free clinics for the uninsured, working poor (with several counties investigating setting up new clinics)
- AIDS education programs for teens
- Senior citizen outreach programs
- Community violence prevention programs
- Community palliative care initiative programs

Initiatives such as these, as well as the longstanding, less publicized involvement of doctors in their local schools, places of worship, charitable organizations, hospitals and elsewhere helps build trust and admiration for our profession. Each one of you has contributed to building the image of the doctor as the patient's friend and advocate.

Leaving this job at the end of the month will be a bittersweet task. My congratulations and best wishes to Richard Geline, MD, who will do a superb job as our spokesperson. Many thanks to the loyal, hard-working and talented ISMS staff who managed to make their president look good, no matter how tough the assignment (believe me, our dues dollars are well-spent). As I look forward to spending more time again with my patients and family (all of whom have been very gracious about my time spent away from Springfield), I can look back on the many new friends I was privileged to make around the state.

Most of all, though, I will treasure the reaffirmation in my mind that Illinois doctors, despite the current turbulent health care environment, care passionately about the health and welfare of their patients. I have faith that we collectively will do whatever it takes to preserve the all important doctor-patient relationship.

GUEST EDITORIAL

Medical staffs must remain savvy in wake of threats

By Elizabeth Snelson, JD

Today, more than ever, physicians who take part in organized medical staffs face a number of obstacles as they practice medicine. From the federal level to the state level, medical staffs are subject to an array of regulations, court decisions and laws that try to wrest control of their patient care from them. However, the best defense might be in the physicians' own hands: By remaining active with their medical staffs and taking strong stands in the development of medical staff bylaws, physicians can protect themselves and their practices. It's also imperative to understand what threats are looming.

On the federal level, the U.S. Health Care Financing Administration has proposed changes in the Medicare conditions of participation for hospitals. Because hospitals must abide by these conditions to be paid by Medicare, the changes could mean that medical staffs will no longer be responsible for their hospitals' quality of patient care. Instead, under the proposed rule change, organized medical staffs would be relegated to a hospital human resource issue. This move would put the hospital in charge of the quality of patient care, taking away the current – and best – structure for quality assurance. When medical staffs are entrusted with this responsibility, they provide an excellent check and balance to assure hospitals' interests are not overriding those of the patients.

The rule change could also eliminate the requirement that organized medical staffs be in place before hospitals can receive Medicare reimbursement.

At the state level, the Illinois Supreme Court's recent decision in *Berlin vs. Sarah Bush Lincoln Health Center* poses a similar threat to medical staffs. Illinois, like several other states, bans the corporate practice of medicine to preserve the interest of patients in a medical setting. In *Berlin*, the Supreme Court ruled that hospital corporations can practice medicine by employing physicians. The court was comfortable with this exception because, after all, hospitals must have an independent medical staff that is responsible for medical care.

Considering pending changes in the federal regulations and this Supreme Court decision, it's even more important for medical staffs to remain independent to act as that check and balance. Will medical staffs really remain independent with the pressures at the federal level and at the state level?

In some cases, physicians have actually helped weaken their own medical staffs' influence. The Joint Commission on the Accreditation of Healthcare Organizations, for example, recently dropped the requirement for monthly medical staff meetings, replacing them with

quarterly meetings. Now, in many hospitals, few physicians attend those meetings, though the responsibilities continue and someone else makes the decisions.

As an attorney who represents medical staffs, I believe it's more important than ever for physicians to become and remain active in their hospitals' medical staffs so the staffs will not be further weakened. I recommend that physicians give careful consideration before their medical staffs are restructured. Physicians must understand the new medical staff structures and how their authority is used – and by whom.

It's imperative to let your feelings be known about changes in the way your medical staff practices. Write to HCFA and to your congressman, take part in your medical society and the political process, and participate in your medical staff. Finally, protect your medical staff through stronger bylaws. They're the best, safest protections you'll have.

Make certain your bylaws protect

medical staff and the patient interests. Remember that the medical staff must be self-governing for accreditation. That means that the hospital does not approve election results, appoint department chairmen or limit eligibility for office to those employed by the hospital or its foundation. Check your bylaws to be certain that medical staff officers really represent you.

Politics should not be the grounds for discipline. If your bylaws permit privileges to be suspended or terminated because of behavior that is "disruptive to hospital operations," be aware that such provisions have been used to terminate the medical staff membership of physicians who have argued against hospital plans to end certain services or build new buildings. Check your bylaws

to be certain that disciplinary actions are taken for clinical deficiencies as determined by clinicians.

Patient care decision-making must remain in the physicians' hands. Such decisions as determining clinical privileges criteria, limiting privileges to contract holders, eliminating or adding medical services, determining medical staff eligibility all have an immediate impact on the quality of patient care in a hospital. The bylaws should require these and all medical quality-related decisions to be made based on medical staff recommendations only. What do your bylaws say?

Snelson is a St. Paul, Minn.-based health care attorney who specializes in medical staff issues.



Ron Ackerman

LETTERS

Few physicians actually leaving medicine

I wish to comment on the guest editorial in the Feb. 20 issue of *Illinois Medicine*, "Generation of doctors being forced into early retirement."

Charles Krauthammer, MD, should make a better effort to present a more balanced view of the situation he's trying to illuminate. First of all, what has failed "to show up on radar" is not a health care crisis, but the predicted mass retirement of doctors leaving the practice of medicine. We have all heard the complaints of embittered, highly vocal physicians who rail against the excesses of managed care and the brutality of the marketplace. And, like Dr. Krauthammer, I have heard many doctors predict the mass exodus. They themselves vow to get out as soon as they can. But, except for practitioners at or near their planned retirement, few have actually done so. To confuse matters further, it's not clear if this is good news, as the writer would have to admit, given the oversupply of

doctors in this country, or bad news.

The truth is that physicians still hold an exalted position in our society, both socially and financially. And the truth is that many physicians, especially the highly paid subspecialists, could not hope to make nearly as much money in any other career. So, despite the pressure and aggravations of medical practice, there are powerful attractions. Like so many observers of the current state of affairs, Dr. Krauthammer is casting about for someone to blame for the disillusionment of physicians. But good whipping boys are hard to find. In a way, we in health care are victims of our own success. However you slice it, the system is changing, as it must.

This is a lot like the psychological phases of death and dying. And physicians are strung out all the way from denial to acceptance. I think we should all have the opportunity to complain and commiserate – including the millions of citizens who have little or no access to basic health-care services, the ones who don't show up on the writer's radar.

J.D. Wright, MD, Joliet

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ISMIE Update

Prescriptions and protocols: Options for easing physician risks

BY MINDY KOLOF

(Part 2 of two parts)

Proper medication procedure is critical to health care. A missing prescription pad, a misread number or a misinterpreted instruction can cause substantial harm to patients in situations that could have been entirely avoidable. Fortunately, many physicians have learned to curb some of their liability by establishing protocols when dealing with the routine of prescribing.

For example, it can be too much of a temptation for some patients when they find an unattended prescription pad. The patient removes a few pages, intending to use them fraudulently. In the best-case scenario, the pharmacist suspects unfamiliar handwriting on the prescription or a premature refill and notifies the physician. In the worst-case, the physician has only a suspicion of who might have stolen it.

Legally, the options are few. If the physician goes to police but keeps the identity of who he suspects to himself, the case probably won't even be investigated. If the physician confronts the patient and the accusation is false, the physician risks a lawsuit.

One missing prescription pad was lesson enough for Chicago pediatrician Jere Freidheim, MD, who now carries them in his pocket at all times. "My pad was stolen 15 years ago, and the pharmacist called to let me know it wasn't my handwriting. I called all the drug stores in the area, and the patient never came back."

Moline cardiologist Richard Snodgrass, MD, however, has never had an incident in his 22 years of practice. That's because he always carries prescription pads with him. "Pads are not left in any public area or in the exam rooms," Dr. Snodgrass said. "When they're not in my pocket, they're under lock and key."



Kenton Nelson/SIS

In addition to limiting access to the pads, Chicago attorney Robert Smith of Lewis & Gellen advises physicians to implement a system for auditing weekly usage. "There should be a way to compare the number of pages in a pad with the number of prescriptions written each week, so any discrepancies would be clear."

Although physician follow-up is not required legally, Smith strongly recommends notifying pharmacies, police and a U.S. Drug Enforcement Agency office if prescription pages are missing. Confronting the suspected individual, however, is only wise, he said, if "you have more than a suspicion. You should have actual corroboration."

CLEAR, WRITTEN INSTRUCTIONS

If there are any concerns about a patient understanding the prescription orders, provide written instructions, said Chicago attorney Bill Rogers of Bollinger, Ruberry & Garvey.

"This is particularly helpful with older patients who may have memory problems and multiple medications to manage."

If appropriate, Oak Park pediatrician Sharon Flint, MD, will even handwrite the name and dosage of an over-the-counter medication for a child

and give the information to a parent. She also distributes dosing charts for commonly used medications.

Experts agree: write prescriptions clearly and legibly. Forget the amusing anecdotes about doctors' illegible handwriting and take a tip from Dr. Snodgrass, who uses great care when writing out prescriptions, eliminates the use of abbreviations and spells out the name of the drug. He is also wary of the opportunity to misread decimals in dosages.

Dr. Snodgrass has an easy method of avoiding this – if .25 mg is the standard dose, he puts a zero to the left of the decimal point so it cannot be mistaken, i.e., 0.25. This is especially important for pediatricians, who are often dispensing minuscule amounts, Dr. Flint said.

SIDE EFFECTS AND THE LAW

For physicians, the buck stops with them when it comes to responsibility for informing the patient about a medication's effects. Smith explained that in a liability lawsuit a pharmaceutical company can claim it's the prescribing physician's duty to warn patients about the indications and contraindications of a drug, because they are acting as the "learned intermediary" between manufacturer and consumer.

A judge's opinion in a pharmaceutical case included this insight into the legal role of physicians in regard to medicines and liability: "The doctor decides which available

drug best fits the patient's needs and chooses which facts from the various warnings should be conveyed to the patient. The extent of disclosure is a matter of medical judgment."

Smith added: "It's difficult to sue a pharmacist in these cases, since it's not their responsibility to verify the appropriateness of the medication. They are only liable if they give the wrong amount or the wrong prescription, not if the medication itself is wrong."

It's clear there are an alarming number of roads that end with the patient ingesting the wrong medicine or the inappropriate dose of the right medicine. But there are just as many ways to avoid medication mishaps from ever happening. Here are some tips from physicians' hard-earned experience and attorneys specializing in medical law:

- ✓ Stick with allergy warnings. Most physicians already place allergy stickers prominently on patient charts, but to avoid any possibility of overlooking them, put them on every page of the chart, Smith recommended. "It may sound obvious, but I recently had a case where a physician prescribed the wrong medication simply because the flap on the folder was turned down, and he couldn't see the allergy sticker. It's also an issue with long-term patients who have amassed pages and pages of notes." For further clarification, Dr. Freidheim endorses the use of "No

(Continued on page 11)

ISMIE seminar offers risk management tips to physicians, office staff

Physicians can learn how to incorporate risk management techniques into the day-to-day operations of their office by attending a three-hour seminar presented by ISMIE.

"Risk Management: An Essential Office Practice" is offered throughout the year to Illinois physicians and their office staffs. Between April and November, 18 seminars are scheduled across the state, including in Collinsville, St. Charles, Quincy and Chicago. Nearly 1,000 people attended last year's seminars.

Participants learn the significance of communication in preventing patient injury and litigation, the principles of good medical record documentation and the development of office

procedures for medical record access and retention.

Physicians can earn up to three hours of Category 1 credit by attending, and any earned hours can be used toward the 50-hour total required to renew their medical licenses for the July 1999 renewal cycle. The state's proposed new CME requirement, included in the Medical Practice Act, was recently clarified by the Illinois Department of Professional Regulation.

The seminar costs \$15 per participant, and registration will only be accepted through the mail. For additional information or to receive a registration form, call the ISMIE Risk Management Division at (312) 782-2749 or (800) 782-4767, ext. 1327.

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“Why are we losing so many doctors?”

Stressing the bottom line – whether progress or hogwash – boosts tension in rural Kewanee.

BY JANE ZENTMYER

Attracting physicians to rural areas isn't an easy task; keeping them can be even harder. Just ask residents from the west-central Illinois town of Kewanee, who have seen five of the 16 physicians belonging to their hospital's active medical staff resign in the past few months. A sixth physician – the chief of the hospital's medical staff – was terminated without cause.

The loss of experienced and well-liked physicians, as well as other good staff members, hasn't gone unnoticed by Kewanee's residents. On March 23, more than 350 people attended a town hall meeting and posed tough questions to Kewanee Hospital's administrators. Ralph Smith, echoing the worries of his neighbors, asked point-blank, “Why are we losing so many doctors and so many good staff members?”

Kewanee's physicians said the answer is that they were driven out because the hospital took away the physicians' ability to be effective patient advocates, and that quality and accessibility of care have suffered as a result. As Jon Gentry, MD, the hospital's former chief of staff, explained, “The medical staff lacks any fair degree of input into the decision-making process in this environment.”

The medical staff has traditionally been responsible for quality of care. But market forces – like the influence of managed care and an increased emphasis on a hospital's bottom line – have initiated a reexamination of the role of the hospital medical staff. As a result, the delicate balance between medical staffs and hospitals is shifting.

“Hospitals are becoming more aggressive, even more than they have been, about making sure the medical staff has little, if any, authority,” said Elizabeth Snelson, an attorney for several hospital medical staffs in Illinois, including Kewanee Hospital's. “Either the administrators are so concerned about their bottom line that they figure the only way they can save the hospital is to absolutely control the medical staff, or the administrators are simply pressured for whatever reason to be in charge of absolutely everything, including medical care, which is beyond their expertise and training.”

This aggressive approach disenfranchises physicians, she said. Many take action against the hospital's administration, such as issuing a vote of no confidence. Other physicians accept jobs elsewhere or resign out of frustration. Hospitals must then turn to providers in other communities in order to get patients the services



Photos by Duane Zehr

◀ Dr. Gentry, (left) and Dr. Svendsen, right, are among 350 Kewanee residents attending a March 23 town meeting.

they need. As Snelson put it, “The highway becomes the only access to care [for patients].”

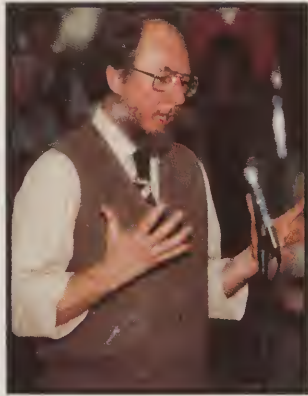
The exodus of Kewanee's physicians, many of whom have been serving the community for 10 years or more, has left the community worried about the health care available to them. “The services we had available up until two years ago we thought were pretty good,” Kewanee resident Joe Stabler said to the audience's applause and cheers.

One physician who recently left Kewanee, population 15,762, was an internist who provided gastroenterological care for the community. When he left, the hospital arranged for board-certified gastroenterologists from out of town to see some of his patients. They now see patients twice a week in Kewanee.

But “twice a week doesn't cut it,” Dr. Gentry said. “They are good physicians, but this is a service that is no longer here for patients. That is, unless they just happen to have a GI bleed when these gentlemen are here.” Some patients, he said, have had to take at least a 45-minute ambulance ride to Peoria in order to receive emergency care.

Roger Holloway, chief executive officer of Kewanee Hospital and Family Health Clinics, said turnover at the hospital is no higher than national averages, and that most physicians have left by their own choice. Along with other hospital officials, he explained that they've been working on improving accessibility to care, and pointed to the Family Health Clinics as an example of their efforts. The clinics, located in Kewanee and surrounding communities, provide specialty and primary care, and offer physician services 24 hours a day, seven days a week, through an on-call rotation plan.

The hospital explained its new approach to health care services in full-page advertisements in a local newspaper: “Our patient-first approach to health care is



◀ Dr. Gentry voiced his concerns about reduced quality of patient care at Kewanee Hospital.

contrary to traditional health care delivery in our organization and in most all other organizations. Traditionally, the physicians, nurses, technicians and others put their schedule ahead of your schedule. We are committed to putting your needs before ours in what we call patient-focused care."

"Pure hogwash," responded R.N. Svendsen, MD, before the meeting. A family practitioner who recently resigned from practice after more than 20 years of service to the Kewanee community, Dr. Svendsen said, "This has never been a doctor's hospital." In fact, Dr. Svendsen and other physicians have said the hospital offers little support to solo physicians and has been driving them out of practice in favor of physicians employed by the hospital or clinics.

Michael Ahearn, MD, medical director of the Family Health Clinics, said that a lot of the changes in Kewanee are happening in other communities. "You're getting exposed to a different way of practicing medicine," Dr. Ahearn told the assembled residents. "We're trying to develop a little bit of a mixture between the old family doctor values and trying to meet the needs of different employers."

Holloway added that the hospital is willing to work with any solo practitioner who wants to set up shop in Kewanee, as long as the hospital's help is within the confines of the law. "We're not about to put the entire organization at risk to give the physician something that may be illegal or fraudulent to do," he said.

That statement just tap dances around the real issue, Dr. Svendsen said later. Although there are fraud and abuse laws, options still exist for hospitals to help solo physicians, he said.

The differences between employed and self-employed physicians is just one of many issues that can divide a hospital medical staff and contribute to its reduced strength, Snelson said. This weakening of medical

staffs, however, has come at a time when they really need to be strengthened.

In October, the state's Supreme Court ruled in *Berlin vs. Sarah Bush Lincoln Health Center* that the state ban on the corporate practice of medicine does not apply to licensed hospitals. ISMS General Counsel Saul Morse said, "The court in Berlin said that one of the reasons they thought it was OK to permit hospitals to employ doctors was the existence of the medical staff as a protection of the physician's ability to make medical decisions."

Strengthening medical

"Hospitals are becoming more aggressive, even more than they have been, about making sure the medical staff has little, if any, authority."

staffs, however, can be a daunting task, Snelson said. Although forces may try to splinter it, a united medical staff can get things done. "That means meetings," she said, "which is the last thing busy physicians want to hear right now."

Some hospitals have suggested that medical staffs drop meeting requirements so physicians don't have to interrupt their busy schedules or face penalties for missing a meeting, Snelson said. But, she added, "If doctors don't go to meetings, things still happen. They just happen without any input from the doctors."

Managed care can also directly affect medical staffs, Snelson said. For example, many hospitals create parallel organizations, such as a physician-hospital organization. Snelson said she's seen documents requiring physi-

cians' hospital medical staff membership to expire unless they join a managed care organization, like a PHO. "That's dangerous," she said. "What that means is that the managed care entities would be in a position to control who is and isn't on a medical staff and will have a great deal of influence over who does and doesn't get access to the hospital."

Physicians should take more of a leadership role, added Theodore Kanellakes, MD, chairman of the ISMS Organized Medical Staff Section. Through hospital staff membership, physicians determine quality of care in a hospital setting by establishing and enforcing standards. If physicians fail to do that, others will be hired to do it, and they may have less expertise than physicians, he said. "Physicians have got to realize that they have a lot of threads in common. Let's look at the common threads that we have and develop our strengths from these."

Instead of alienating the medical staff, Snelson said a strong partnership between the hospital and medical staff seems more logical than alienating physicians. "If you make the medical staff stronger, the logical outcome is that physicians would be closer to the hospital, which is what the hospital should want," she said.

The 350-plus Kewanee residents who attended the town hall meeting certainly want their physicians to remain in the community. Kewanee resident Jim Tossell said he wants Hipolito Lopez, MD – a surgeon who has provided more than 20 years of service to the community – to stay despite his recent decision to leave. He encouraged hospital officials to do whatever they could to keep him. "The people who are leaving have been here for such a long, long time," Tossell said. "I don't think we're ready for these changes." ■

▼ Dr. Svendsen questions whether Kewanee Hospital is a doctor's hospital.



▼ The exodus of Kewanee's physicians has left the community worried about the quality of health care still available to them.



▲ Kewanee resident Joe Stabler, (left) expresses his concerns to Roger Holloway, chief executive officer of Kewanee Hospital and Family Health Clinics.

Patient rights

(Continued from page 1)

version of an ISMS managed care patient rights bill failed in committee. Yet a similar managed care reform proposal sponsored by Rep. Mary Flowers (D-Chicago) was approved by the House Health Care Availability and Access Committee and is pending for a vote on the House floor. The Flowers-sponsored H.B. 3265 includes language that would ban gag clauses, establish grievance procedures, require plans to disclose specific information and allow hearings for physician termination.

A key amendment approved in Flowers' bill allows health insurance carriers, health care plans and other managed care entities to be sued for harm to an insured caused by failure to exercise ordinary care. "HMOs should be liable for rules put forward by them," Flowers said. "If we can sue the doctor, we should be able to sue the HMO. Basically it would allow a patient to sue an HMO when they feel they've been denied proper care." The bill is supported by the Illinois Trial Lawyers Association.

In the opposite chamber, Sen. Tom

Walsh (R-Westchester) predicted that if the Flowers-sponsored managed care bill passes in the House, it will fail in the Senate – a repeat of what happened one year ago. "We're not going to pass anything like it," said Walsh, chairman of the Senate's managed care subcommittee. The bill is too tough on insurance companies and would chase them out of the state, leaving consumers without coverage, he explained.

After the Legislature failed last year to pass managed care reform, the Senate conducted a series of statewide hearings to take testimony from individuals and special interest groups. The Senate is still in the process of developing a bill, which Walsh said will be a hybrid of proposals from various interest groups. "We have been meeting with the Medical Society, HMOs and businesses. It's really hard to find something everyone can agree on," he said. "We want everyone to give us their bottom line."

Walsh vowed that the Senate would give a managed care patient rights bill over to the House before the end of the session.

In addition to the comprehensive reform bills, a piece of insurance reform advanced in the General Assembly. H.B.

3427, supported by ISMS, requires insurers to notify enrollees of their right to designate a woman's principal health care provider and to provide a list of participating women's health care providers within 30 days after a request is made.

A bill supported by managed care interests suffered defeat. H.B. 3489, which would have denied physicians the right to bill a patient for services not

paid for by an insurance company or HMO, failed in committee.

ISMS will continue to move forward this session on insurance reform legislation to protect patients rights and assure due process for physicians. "The time is right to pass a comprehensive bill," Dr. Jackman said. "It's important our members get involved in putting pressure on their legislators."

We need to remind our legislators that managed care abuses are becoming a major problem for the people they represent."

Call to action:

Don't let big business, insurance kill managed care reform

ISMS members are urged to lobby their legislators to vote in favor of insurance reform and patient rights legislation pending in Illinois.

An action alert was recently mailed to members in key Senate districts directing physicians to rally legislative support for the ISMS Managed Care Patient Rights Act, S.B. 1666. The needs of Illinois patients and physicians should not be bottled up, it states, by a self-interested power play by business and insurance lobbyists. "Big business and insurance interests are everywhere ... lobbying actively to thwart prospects for reform."

The alert outlines eight key principles physicians must ask to be included in any insurance reform. These include a gag clause ban, due process for physicians who speak out on their patients' behalf, standardized rules to file grievances, timely access to and coverage for emergency care, patient choice of physician, information disclosure, utilization review standards, a ban on health plans transferring liability to physicians through insurance contracts and a provision that would allow patients to sue managed care plans for negligent decisions.

Physicians should phone their senators, set up meetings, fax messages and organize colleagues and patients to deliver this message to Springfield. To get the name of your state senator, call ISMS at (800) 782-4767 or (312) 782-1654. ■



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Panel looks at the status of Illinois women

REPORT: Commission says many still face disparities between their goals and their lives.

BY CHRIS PETRAKOS

[CHICAGO] Women's health issues were front and center when the Commission on the Status of Women in Illinois presented its interim report to Gov. Jim Edgar March 20 in Chicago.

ISMS President Jane Jackman, MD, serves as chairman for the commission's health group. She said the interim report was only a beginning, though a positive one. "We hope the information contained in the report will be discussed in different forums so that potential solutions can emerge," she said.

"My hope is that the report of the commission will be meaningful and will be widely disseminated so that we can get some changes to improve the health care status of women in Illinois," Dr. Jackman said.

The commission report was intended to frame the most important issues facing the state today. Its interim report, presented to Edgar by commission chairperson Paula Wolff, found that, despite some great successes for Illinois women in the last 15 years, many still face serious disparities between their goals and their lives.

For example, Wolff said, women do not have access to necessary support systems and resources. In some cases, such resources are of poor quality; in many



EDGAR (LEFT) listens as Wolff presents the commission's interim report on the status of women in Illinois.

cases, they don't exist at all. Women's health services remain fragmented and out-of-reach, particularly for poor, high-risk and non-English speaking populations. Available child care is often insufficient, she said.

The report also underscored the fact that women are unsafe in our society. In

1996, there were 35,000 adults who sought shelter. Ninety-seven percent of those were women, and 17,000 – nearly half – were turned away.

Further, Wolff cited economic inequality, as well as inequalities in educational, training and mentoring opportunities as other major obstacles for women.

Dr. Jackman expressed her belief that every aspect of the community will be needed to facilitate changes suggested by the report. "For example," she said, "in our society, women traditionally take on the role of caregiver to children, ailing parents and sometimes an elder spouse. In addition to these responsibilities, most women also have full-time jobs. Society has not looked at the complexity of these unique roles; the commission is. Society needs to look at how to support women in caregiver roles so that they can effectively balance responsibilities at home and in the workplace."

The commission wants all health insurance plans to offer a wider range of mental and reproductive health services for all employees. It also wants providers to become more culturally and socially aware of the unique circumstances impeding certain populations of women – particularly those with special needs – from obtaining high-quality care. In

addition, the commission wants payers to educate consumers on their rights under insurance policies, teaching them how to navigate the health care delivery system and how to file grievances.

As its chairperson, Wolff talked about what the commission plans to do between now and the December deadline for its final report. "We would like businesses that have created family-friendly workplaces to talk to other businesses and create a network in the private sector emphasizing the importance of implementing such policies," she said.

"So businesses will understand how good it is for their bottom line. We want to encourage health care researchers to look at women's health care issues. We will also dialogue with women around the state about the obstacles they face and what solutions they can suggest. Finally, we will have round-table talks with legislators and business owners to get their input."

Edgar said he felt the report was a good starting point. Although he said that government has a role to play in bringing about change, he was firm in his emphasis that not only government, but individuals, community groups and the private sector need to share responsibility for change.

"There is no doubt that there are many areas where government needs to step forward – such as in child care – with more resources," Edgar said. "But I think an important message needs to be sent that it will take all of society, not just government."

Protocols

(Continued from page 6)

Known Allergies" stickers as well. He also does a verbal double-check with patients before prescribing any medication.

- ✓ Beware of drug interactions. Since giving one drug with another may lead to abnormally high levels of either drug, keeping an updated list of patient medications is critical. Checking in the Physician's Desk Reference is standard operating procedure for most physicians and nurses.
- ✓ Use a medication flow sheet. For patients on anticoagulants, Dr. Snodgrass uses a form indicating when various testing is to be conducted and when to call for the results. Nurses also check a master list, and if the lab has no record of a patient being tested when indicated on the sheet, a gentle reminder phone call is made to the patient.
- ✓ Keep it simple. "The PDR lists so many side effects for each medication that standard instructions work best," Smith said. "Telling patients to contact your office in case of adverse effects is much better than going through a laundry list of possibilities." That kind of uncomplicated style has served Dr. Snodgrass well during his more than two decades in practice. "I don't provide written materials or fancy videotapes, just verbal instructions, and I always ask patients if they have any questions at the end of a visit."

A final piece of advice: don't single-handedly shoulder the burden for avoiding prescription errors. "Have a system in place where two people must drop the ball for an error to occur," Smith said. ■

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Resolution

(Continued from page 1)

are the subject of eight resolutions, most calling for ISMS to oppose implementation of these codes and to work for more reasonable guidelines. One resolution describes the requirements as too detailed, too restrictive and too time-consuming for physicians and their staffs.

"Physicians view the regulations as having a negative effect on their practice and their ability to provide quality care," Dr. Schneider said. "They are concerned that the complex documentation system subjects them to fraud and abuse allegations simply for incorrectly following rules and regulations."

Specific managed care topics raised by delegates this year include credentialing, profiling, physician deselection and patient protections. One resolution requires that physicians receive a copy of their practice performance profile information at least annually from organizations retaining such information. Another encourages ISMS to support legislation requiring managed care entities to contact newly enrolled patients within 30 days to ascertain if they have any active health care problems and to arrange provisions of needed care expeditiously for those problems.

Several resolutions deal with the relationship between hospital medical staffs and hospital governing boards. One resolution would establish ISMS policy to condemn any retaliation against medical staff representatives

by hospital administrators.

The manslaughter conviction of a New York physician for a professional error prompted two resolutions against the criminalization of medical mistakes. One of the resolutions, in addition, calls for ISMS to support the New York physician as he pursues a pardon.

Public health resolutions include two that encourage ISMS to cause legislation to be introduced mandating seat belts in school buses, and one that seeks ISMS policy to expand physician awareness of domestic violence signs and symptoms.

Another group of resolutions seeks to reverse ISMS policy of mandatory unified membership with the American Medical Association. ISMS members should "determine for themselves whether they wish to be identified with AMA activities and programs," reads one resolution. Reasons physicians prefer deunification, according to one resolution, are because they don't want to belong to both levels, because they cannot afford the expense, or because they respect free choice. Two related resolutions deal with the subject of AMA product endorsement.

Although the resolution deadline is past, late resolutions may be submitted before 6 p.m., April 23, the day prior to the opening session of the House of Delegates. Late resolutions must be recommended for consideration by the Committee on Rules and Order of Business. By a two-thirds majority vote, the delegates may override the recommendation. Generally, the House is not inclined

Hastert

(Continued from page 1)

105th Congress on issues such as health and insurance reforms, and patient rights legislation.

Hastert, 56, was first elected to the U.S. House in 1986 and has served as his party's point man on health care reform since 1992. He was the Republican representative to First Lady Hillary Rodham Clinton's Health Care Task Force and was the chairman of the Speaker's Steering Committee on Health and the Resource Group on Health.

His other duties include service on the House Commerce Committee, which handles food, health and drug issues; energy policy; interstate and foreign commerce; broadcast and telecommunications policy. The committee reviews nearly half of all legislation that eventually reaches the floor of the U.S. House. As chief deputy majority whip, Hastert is responsible for advancing the party's agenda on the House floor.

Before joining the U.S. House, Hastert spent six years in the Illinois House of Representatives. During that time, he spearheaded legislation on child abuse prevention, property tax reform, educational excellence and economic development.

He graduated from Wheaton College in 1964, and earned his master's degree from Northern Illinois University in 1967. He taught government and history for 16 years at Yorkville High School before beginning his political career. He now lives in Yorkville with his wife and two children.

to allow late or emergency resolutions without stringent justification.

Resolutions are assigned by the speaker to a reference committee for discussion and fact-finding. Any ISMS member may testify at reference committee hearings. Following the conclusion of testimony, the reference committee will meet in executive session to develop recommendations to the full House.

During their three-day stay in Oak Brook, delegates can take a break from their work to attend social events. The

ISMS Alliance is hosting a reception 8:30-10 p.m. on April 23.

President's Night, honoring ISMS President Jane Jackman, MD, will be held 7 p.m., April 24, in the Grand Ballroom. The theme of the casual-attire event will be "American English - A Tribute to the Beatles," with dancing to the Jane Hartman Trio. April 25 will kick off at 7 a.m. with the Public Affairs Breakfast featuring U.S. Rep. J. Dennis Hastert, Chief Deputy Majority Whip of the U.S. House of Representatives (R-Ill.). ■

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Medical Society

(Continued from page 1)

should prevail. "Our hearts go out to the injured," Dr. Herr said, adding that in 22 years in practice he has witnessed both the benefits of vaccine and children injured by them. "The millions protected by vaccines clearly outnumber those possibly injured." But, he said, "We're concerned with the health of all children, not just some."

Barbara Loe Fisher testified firsthand about the hardship on a family when a child is injured by a vaccine.

"When it happens to your child, the risks are 100 percent," said Fisher, whose oldest son was brain injured from a DPT shot at age 2. "The parent, not the pediatrician, state legislator or public health official, is left to cope for the rest of their life." Fisher is a cofounder and president of the National Vaccine Information Center, an organization "dedicated to preventing vaccine injuries and death through public education."

Fisher said her organization is not against vaccine requirements, but does support an "informed consent" system

that would let parents reject a required immunization.

State Board of Health member Karen Scott, MD, said she is troubled that informed consent would be used by some parents as a catch-all excuse for avoiding immunizations. "So what would be the difference between informed consent and no requirements?" she asked Fisher.

Although the hearings brought the entire immunization process to the table, the Hepatitis B vaccine triggered the debate. The three-series Hepatitis B vaccine will be required this fall for all

children entering fifth grade and youngsters over the age of two who are enrolled in prekindergarten programs. Some parents and anti-vaccine groups criticized the addition of the Hepatitis B vaccine to the schedule because children do not fall in high-risk groups for contracting the disease, groups that include intravenous drug abusers and people with multiple sex partners.

Dr. Jackman said that while it is true that Hepatitis B is most commonly spread by sex or needle-sharing, the AAP has reported that there is a growing body of evidence demonstrating the spread of infection under certain conditions through classroom contact in schools. "We cannot afford, ethically or financially, the false security of the assumption that vaccination can be optional because the disease is spread by behavior."

ISMS is not alone in recommending the Hepatitis B vaccination, Dr. Jackman said. Support includes the U.S. Centers for Disease Control and Prevention, the AAP, the American Academy of Family Physicians and the American College of Obstetricians and Gynecologists among others.

The State Board of Health will take testimony gathered at the hearing into consideration as it develops a recommendation to Illinois Department of Public Health Director John Lumpkin, MD, on current childhood immunization requirements and the process for setting and revising them. The agency is charged with determining immunization requirements for Illinois school children.

A bill pending in the General Assembly could expand public input into future immunization requirements. The proposal, which already passed the Senate, establishes an advisory committee to be made up of persons with knowledge of immunization issues. The committee would review and make recommendations to the IDPH on proposed immunizations.

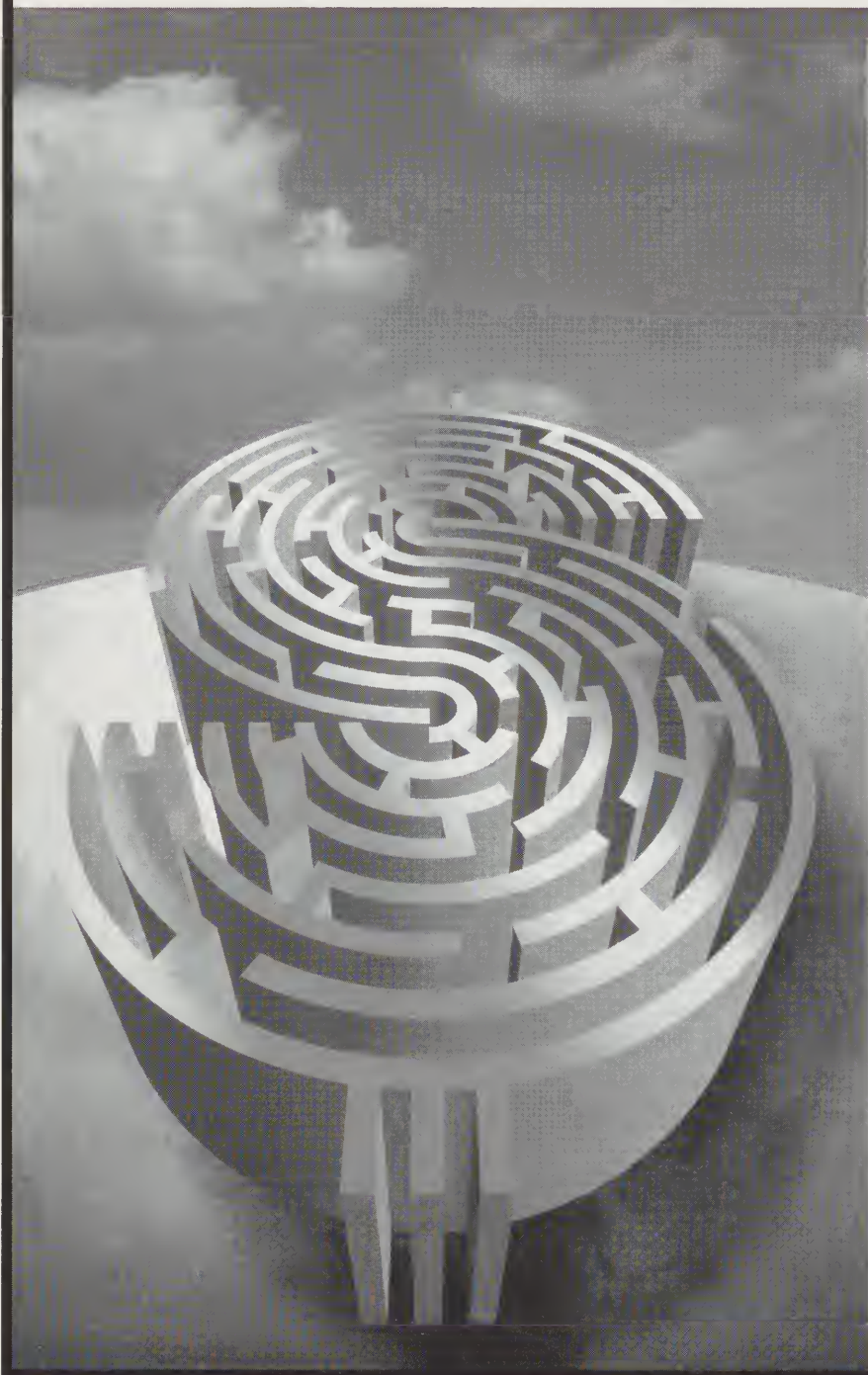
Vaccine proponent Robert Daum, MD, professor of pediatrics at the University of Chicago Department of Pediatrics, said that while no vaccine is 100 percent safe, adverse reactions should not overshadow the benefits. "I remember when there were 60 to 70 cases a year at my children's hospital with [Haemophilus influenzae Type B]. Many ended with brain damage. Now we have a vaccine and we've seen one case in the last three years."

Opposing sides on the issue should work together, he said. Specifically, physicians could do a better job of reporting reactions so data on potential risks can be accurately analyzed. The immunization education process for physicians and parents should be improved.

State Board of Health chairman James McGee, MD, said the hearings have brought to the board's attention the need to broaden education to physicians and parents about potential negative reactions. Several parents complained that there is nothing in the immunization process to inform parents about immunization risks. "We will be looking to all sectors including organized medicine for help in improving communications to parents about risks," he said.

Dr. Jackman said ISMS would be happy to assist in communications measures the board undertakes. ■

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Updates on health-related legislation

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Illinois Medicine

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*How much should a
physician disclose
about personal health?*

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Physicians' advocate takes charge

As managed care continues to erupt, new ISMS President Richard Geline, MD, said he is prepared to unite physicians in the battle against the forces of big business. "It's not my agenda," Dr. Geline stated. "It's the agenda of the decade."

For more details, see page 8.



Compliance plans help untangle antifraud laws

ACTION: Proactive tool can be tailored to the needs of each physician's practice. BY JANE ZENTMYER

[CHICAGO] The federal government's zealous efforts to fight Medicare fraud have left physicians worried that they may be subjected to an intrusive government investigation. But a proactive tool called a compliance plan can help physicians ensure that their activities adhere to federal antifraud and anti-abuse laws.

Compliance plans originated during the federal government's crackdown on fraud and abuse in the defense industry, according to an American Medical

Association spokesperson. The idea was to create an internal structure or process that detected and weeded out potentially fraudulent activities before they occurred. Now that the government has focused its antifraud efforts on the health care industry, compliance plans have been adapted for those involved in health care, including physicians.

To help physicians establish such plans, the AMA has released guidelines outlining key elements to be included in any (Continued on page 14)

House next battleground for new nurses' licensing bill

LEGISLATION: Bill does not include corporate practice restrictions or the licensure of nurse anesthetists. BY JANE ZENTMYER

[SPRINGFIELD] At the start of this legislative session, the Senate Republican leadership asked ISMS and the nurses' groups to negotiate on the controversial issue of licensing advanced practice nurses. The results of those discussions, which reflect many hours of work over several weeks, led to a tentative compromise bill that passed the Senate 58-0 on April 2.

"We're very pleased with the progress that's been made," said ISMS President Richard Geline, MD. The compromise bill "upholds the concept that physicians – the individuals with the most background, training and education – must be involved in the delivery of medical care," he said.

During the negotiations, the ISMS Executive Committee, the ISMS Council on Education and Health Workforce, and medical specialty groups reviewed various proposals and suggested acceptable changes throughout the negotiating process. The ISMS Governmental Affairs

Council also reviewed the bill and recommended its support to the ISMS Board of Trustees.

S.B. 1585 only licenses clinical nurse specialists, nurse practitioners and nurse midwives, who as a group now want to be referred to as advanced practice nurses. Disagreements

remain on the licensure of nurse anesthetists and corporate practice restrictions on APNs, and senators chose to omit both provisions from the bill. Negotiations on these remaining issues will continue as the House considers S.B. 1585.

(Continued on page 13)

Tell ISMS what's on your mind

ISMS wants to know about your biggest concerns: difficult managed care contracts, intrusive regulations, dwindling autonomy? A survey will be mailed to ISMS members within a few weeks. Take a few moments when you receive it and let us know how the Society can better represent you.

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Court ruling clears way for merger between Illinois, Texas Blues plans

BIGGER IS BETTER: Policyholders could see reduced costs, lowered premiums. BY LINDA MAE CARLSTONE

[AUSTIN, TEXAS] A bigger Blue could be coming to Illinois, now that a major roadblock to an Illinois-Texas Blue Cross Blue Shield merger is out of the way.

The 126th District Court in Austin ruled recently that the proposed merger of the two insurance companies does not violate Texas state law, as had been alleged in a suit filed by Texas Attorney General Dan Morales. The suit sought to

block a July 9, 1996 agreement for the Texas company and the Illinois company to merge.

Jointly, the two companies will have about 5 million enrollees, 10,000 employees and \$6.8 billion in annual revenue. Illinois currently is clearly the bigger of the two, with 2.9 million enrollees, compared with 1.9 million in Texas Blue (Continued on page 14)



John McNulty

GOVERNMENT AND HEALTH CARE leaders break ground to begin the construction of the new Cook County Hospital, scheduled for completion in 2002.

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Medical Society monitors health-related bills

ACTION: Legislators look at physician liens, women's principal health care providers. BY JANE ZENTMYER

[SPRINGFIELD] As the Illinois General Assembly's session progresses, the ISMS Governmental Affairs Council keeps track of hundreds of bills of interest to its member physicians, including:

PHYSICIAN LIENS

A bill that would limit the amount all health care providers could receive under a lien act to a total of one-third of a

judgment or settlement is currently stalled in the Illinois House of Representatives. H.B. 2564 is sponsored by Reps. Thomas Dart (D-Chicago) and Mary Flowers (D-Chicago).

ISMS opposes the bill because it would reduce fair compensation for services provided by physicians and override an Illinois Supreme Court decision released last year in Panky

Burrell vs. Southern Truss et al.

In this case, an appellate and circuit court attempted to combine a hospital's and two physicians' liens to limit both types of providers reimbursement to one-third of the case's settlement. However, the Supreme Court overturned the lower courts' decisions and said the law entitles the hospital to up to one-third of the case's settlement and the physicians to up

to one-third of the case's settlement.

The existing lien laws allow each type of health care provider, such as physicians, hospitals and dentists, to receive up to one-third of a judgment or settlement.

MEDICAID REIMBURSEMENT

H.B. 2478 allows physicians and other health care providers who are underpaid by Medicaid, which is administered by the Illinois Department of Public Aid, to recover the amount of the underpayment, including using it to offset the amount of overpayment the state makes to a provider. The bill passed the House 112-2 on March 27 and is now pending in the Illinois Senate.

"It's leveling the playing field," explained Rep. Thomas Johnson (R-West Chicago), one of the bill's sponsors. Currently, the state doesn't have to reimburse physicians or others for any underpayments found during an audit, but the providers must return any money that they received as a result of overpayments. ISMS supports the bill.

WOMEN'S PRINCIPAL HEALTH CARE PROVIDERS

On March 25, the Illinois House passed the ISMS-backed H.B. 3427 by a vote of 115-0. Sponsored by Rep. Rosemary Mulligan (R-Des Plaines), the bill requires insurers to notify enrollees of their right to designate a woman's principal health care provider and to receive a list of those providers within 30 days after they make a request. The bill now goes to the Senate, where Sen. Laura Kent Donahue (R-Quincy) is its lead sponsor.

Mulligan said she introduced the legislation after a woman complained that her health plan wouldn't reveal the names of its women's principal health care providers so she could exercise her legal right to designate one. "Repeatedly, we find that women don't know that they are allowed to have an Ob/Gyn as a principal health care physician," Mulligan said.

The law that allows women to designate a principal health care provider became effective in 1996. ISMS strongly supported the law based on policy the ISMS House of Delegates adopted at its 1995 annual meeting and reaffirmed the following year.

MASTECTOMY COVERAGE

H.B. 2645, which is stalled in the House, would require insurers to cover reconstructive breast surgery performed after a mastectomy, as well as any prosthetic devices that are needed to achieve or restore symmetry following a mastectomy.

The bill, sponsored by Rep. Gwenn Klingler (R-Springfield), also requires insurers to cover reconstructive surgery for children with deformities. ISMS supports the bill. ■



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REPORT for Illinois Physicians

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- the name of the device (trade name, common or usual name, and classification),
- a detailed narrative description of the device,
- a copy of the agreement between the company or manufacturer and the provider, including the details of provider participation in the study,
- a copy of the study protocol,
- an institutional review board approval letter, or a statement from the provider assuring that approval has been obtained from the study institution,
- a copy of the protocol used for obtaining informed consent from beneficiaries for their participation in the study, and
- copies of two full-text articles of peer-reviewed publications addressing the topic of the study.

To determine Medicare coverage, the Health Care Service Corporation will review the data submitted; see references in 42CFR 405.205(a)(2).

To obtain a coverage ruling, please submit the requested to:

Health Care Service Corporation
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300 E. Randolph St., 13th floor
Chicago, IL 60601

State's TB cases dip to century's low

[SPRINGFIELD] The number of Illinois tuberculosis cases in 1997 fell below 1,000 – the first time that's happened in more than a century, Illinois Department of Public Health officials have announced. "This is a public health success made possible by the continued partnership of federal, state and local health departments," said John Lumpkin, MD, the state's public health director.

More than 15,000 tuberculosis cases were reported 80 years ago, and 8,579

people died of the disease, according to IDPH. In 1997, there were 974 cases recorded, which is an 8.1 percent decline from the previous year. The number of deaths from TB also reached an all-time low of 63 in 1996, the most recent year for which statistics are available.

Chicago reported 588 TB cases in 1997, a decrease from 669 cases in 1996. Cook County and the five collar counties – Lake, McHenry, Kane, DuPage and Will – reported 855 TB cases in 1997 compared with 949 cases in 1996.

"Despite this good news, however, we should not forget the lessons we learned in the 1980s when we let our guard down and TB came back in a form more deadly than before," Dr. Lumpkin said. TB re-emerged in the 1980s at the start of the AIDS epidemic, and health departments were ill-equipped to respond to a multidrug-resistant TB.

Additional resources from the federal government helped to bring tuberculosis back under control, according to IDPH. The U.S. Centers for Disease Control and Prevention's spending on TB increased from almost

\$45 million in 1992 to \$145 million in 1997. Ongoing efforts to control and prevent TB include development of diagnostic tools to better identify drug-resistance and more international collaboration.

In Illinois, tuberculosis is increasing among individuals born in other countries. Foreign-born cases in Illinois increased from 15.4 percent in 1994 to 23.1 percent in 1997. "TB is not just a problem in Illinois or the United States. It is a global problem," Dr. Lumpkin said. "International collaboration is necessary – as it was in the fight against smallpox – to eliminate TB."

References: 1. Gordeuk VR, Brittenham GM, Hughes M, Keating LJ, Oppitt JJ. High-dose carbonyl iron for iron deficiency anemia: a randomized double-blind trial. *Am J Clin Nutr*. 1987;46:1029-1034. 2. Gordeuk VR, Brittenham GM, McLaren CE, Hughes MA, Keating LJ. Carbonyl iron therapy for iron deficiency anemia. *Blood*. 1986;67:745-752. 3. Harvey JA, Zobitz MM, Pak CYC. Dose dependency of calcium absorption: a comparison of calcium carbonate and calcium citrate. *J Bone Miner Res*. 1988;3:253-258. 4. Sakhaee K, Baker S, Zerwekh J, Poindexter J, Garcia-Hernandez PA, Pak CYC. Limited risk of kidney stone formation during long-term calcium citrate supplementation in nonstone forming subjects. *J Urol*. 1994;152:324-327. 5. Harvey JA, Zobitz MM, Pak CYC. Calcium citrate: reduced propensity for the crystallization of calcium oxalate in urine resulting from induced hypercalcaemia of calcium supplementation. *J Clin Endocrinol Metab*. 1985;61:1223-1225. 6. Food and Drug Administration. Iron-containing supplements and drugs: label warning statements and unit-dose packaging requirements. *Federal Register*. 1997;62:2218-2250.

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EDITORIAL

Grass-roots efforts pay off

From the beginning of this democracy, Americans have known that lawmakers listen if you speak loudly enough – and reasonably enough. This was proven recently with legislation that ISMS was heavily involved with as it moved through the Illinois Senate. While senators studied various bills that could have licensed advanced practice nurses, ISMS members spoke up and presented their views. The Senate took the appropriate action by crafting a compromise bill, S.B. 1585, that reflects many of the Society's opinions, thanks to the calls and letters of Illinois physicians.

ISMS members knew that nurses' groups had been waging active campaigns to meet with lawmakers about a bill they endorsed that would have inappropriately licensed APNs. And often the groups presented information that didn't tell the entire story. Physicians responded with their own calls and letters. Despite hearing the nurses' messages about licensure, senators found ISMS' arguments more convincing in many areas.

For example, Society members contacted their legislators about confining the collaborative agreement between physicians and APNs to the services normally offered by the physician in his or her clinical practice. The nurses' organizations had lobbied for loose agreements between APNs and physicians that would have allowed for inappropriate practice relationships based more on entrepreneurial opportunities than on sound medical practice. In

addition, ISMS wanted a clarification about how guidelines and standing orders are developed and signed by physicians and APNs, and wanted to restrict physician-delegated APN prescribing authority to Schedule III, IV and V substances, not Schedule II. ISMS prevailed with both requests. The new bill also includes appropriate standards for "grandfathering."

Despite this encouraging development, the effort to pass a reasonable APN licensing bill is far from over. The Illinois House of Representatives is scheduled to consider S.B. 1585 later this month and will debate several additional issues, such as the licensure of certified registered nurse anesthetists.

As successful as the physicians were in helping to create a compromise bill, it is imperative that ISMS members continue their grass-roots efforts. Call and write your local representatives. Explain that state law should recognize that nurses and physicians significantly differ in training and skill. Emphasize that, though APNs can play a key role in delivering quality health care to patients, at no point should they be considered substitutes for physicians.

If passed, S.B. 1585 could spell out that point clearly as state law, and it deserves continued support from ISMS members as it moves through the House. To get the name, address and telephone number of your local lawmakers, call ISMS at (312) 782-1654 or (800) 782-4767.

PRESIDENT'S LETTER

Looking forward to the challenges that lie ahead

Richard A. Geline, MD



The 1998 ISMS House of Delegates Annual Meeting has been completed, new officers are in place, and leadership and staff now have a series of reports and resolutions giving them and the Society direction for the coming year. As the Society's new president, let me share a few personal thoughts and observations on how I view what lies ahead.

To begin with, being elected as your president is, at the very least, most flattering. Looking back through the years at the physicians who have served in this role, I see a long list of dedicated, talented, committed and able individuals. Being selected as part of this group of people is a compliment that I accept with humility. I resolve to maintain the high level of contribution established by my predecessors.

The year ahead will present numerous challenges. A heavy schedule of appearances with groups of physicians and county societies, media interviews and ... oh yes ... a twice-monthly president's letter, all coming on top of demands of practice and family. This year promises to make me a very busy person. There are new places to go, new people to meet, new things to do, new thoughts to hear and new opportunities to discuss the affairs of the day. I must admit I am looking forward to it!

The duties of leadership in organized medicine are important, if only because of the demands placed on medicine. As physicians, our world is changing rapidly – by the day, by the week and by the month. We face continued influence from the federal, state and local levels of government, as well as from the managed care industry. Forces from everywhere seem to want to introduce themselves or

take control of medicine. The catalog of issues we face is long and well-known, including, but not limited to:

- The progressive erosion of our ability to think, function and act as professionals on behalf of patients, as we have all been taught.
- The promise of a more-threatening malpractice climate with its accompanying rise in premiums that likely lies ahead. With the ruling from the Illinois Supreme Court striking down our hard-won 1995 tort reforms last year, the future is most uncertain.
- The progressive tightening of the bureaucratic change demanding more paperwork in compliance with detail far beyond that necessary for the normal practice of medicine.
- The plan for harsher penalties for the actual or perceived departure from standards that could allow an innocent error or oversight to be termed "fraud and abuse."

Who stands up and speaks out on behalf of physicians and the patients we serve? The

answer is quite simple: organized medicine at the national, state and local levels.

Considering the climate of change rapidly swirling around us, there is need for an ongoing and continuous voice of the physician community now more than ever. I look forward to serving you in this role and providing that voice. Please join me and send your thoughts on any and all topics. No matter is too small to deserve attention. Remember, we can do more by working together than by working alone.

Once again, thank you for the honor and privilege of allowing me to step into this job. I look forward to the year ahead.

*"There is need
for an ongoing and
continuous voice of the
physician community
now more than ever."*

GUEST EDITORIAL

Physicians at a disadvantage in long-term care facilities

By William L. Kempiners

Consider the surgeon in the middle of a complicated procedure, using her intellect and experience to make second-by-second decisions that will affect whether her patient experiences a fulfilling life after he leaves the hospital. "Scalpel, please, nurse," the doctor requests. But the nurse just backs away, and lifts her hands in embarrassment. "I can't."

Of course this situation appears ludicrous, but today's long-term care nurses are being forced to imitate this scenario in Illinois facilities. Starting a dangerous precedent, Illinois lawmakers have begun passing laws that remove oversight from physicians and place long-term care nurses in the middle of a battle between doctor's orders and a surveyor's subjective viewpoint. Long-term care nurses must, at the very least, question a doctor's orders, and in some cases, refuse to act on them or face a citation.

The long-term care industry, including physicians, has played a major role in developing many of these guidelines which are intended to be used as tools to aid the thought processes of caregivers

(and surveyors) to ensure that all necessary medical steps are being taken on behalf of a resident.

In the past decade, the federal government has created a widening chasm between nurse and physician due to the tightening of certain regulations. Under the Omnibus Budget Reconciliation Act of 1987, the U.S. Health Care Financing Administration developed more specific regulations for physician care in long-term care facilities. For the first time, regulations like "the resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter" were created by HCFA, with guidelines spelling out a strict interpretation of the rule. Though the regulations were well-meaning, physicians were really losing the right to apply what they believed to be common sense treatments, such as determining the frequency of their visits. Nurses were put on notice by the federal government that a physician decision was not necessarily the last word.

Another OBRA regulation stated that residents "must be free from

unnecessary drugs" including "duplicate therapy." If a physician prescribed, for example, two laxatives without explaining the reasons why, a nurse would either have to confront the physician to explain his or her reasoning, give the prescribed medications and face a citation, or disobey the physician's orders. If the physician refused to chart a reason why he or she was prescribing certain "duplicative" medications, the nurse was then torn between doctor and surveyor. Surveyors would not accept the reasoning of "the doctor said so," and in Illinois, facilities reported that surveyors were very strict about enforcing this guideline. Numerous facilities were cited for not complying with this regulation, and nurses were officially put on the hot seat.

Several years ago, state legislators turned their attention to OBRA guidelines involving the use of physical restraints and psychotropic medication. Unfortunately, some believed that turning these guidelines into law would strengthen them, despite evidence that regulations like these were already creating gaps between interdisciplinary team members. With this law, medical practice and decision-making was taken out of the hands of the true professionals and placed in the hands of the state legislators or surveyors.

If turning guidelines into Illinois state law becomes a trend, there will be side effects which have the potential to erode quality care for the 100,000 long-term care residents statewide. Long-term care

efforts to reduce the use of outdated techniques like unnecessary restraints or to follow other guidelines succeed only in a system where a physician's education, clinical expertise and knowledge of the resident lead the interdisciplinary team.

As medical practices change, so our profession changes. Our industry's track record of the last two decades proves long-term care providers are willing to make the tough choices to ensure we offer the highest in quality care. At all times, we welcome state and federal guidelines that make the delivery of quality care even better and help all caregivers make more informed medical decisions.

Yet the long-term care community does not necessarily believe that laws that divide the interdisciplinary team help our residents. All of us who spend our lives in the pursuit of aiding others along the continuum of care must work together to stop unneeded and unwarranted legislation from endangering our ability to serve our clients. If this type of super-legislation becomes a trend in Illinois, resident care will suffer. If the state begins to make all medical decisions, we may be forced to back away in embarrassment from the people we serve.

William L. Kempiners is executive director of the Illinois Health Care Association. He is a former state legislator and former director of the Illinois Department of Public Health.

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ISMIE Update

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Ruling raises questions about physician health disclosures

BY KAREN TITUS

A recent appellate court ruling has cast a troubling shadow over the physician-patient relationship, raising questions about the obligations physicians have to disclose their medical conditions to those they treat.

In a unanimous decision written by Justice Alan Greiman, the First District Appellate Court held that a physician who fails to advise patients of his or her HIV status is potentially liable for infliction of emotional distress, ISMS General Counsel Saul Morse said. The ruling could create more than just an added burden for physicians, he added. "The decision is also very far off the spectrum in terms of what previous rulings have been.

There really aren't any other decisions, especially in Illinois, that are analogous to this."

The case, *Doe vs. Noe et al.*, involves a now-deceased Illinois physician who performed gynecological invasive surgery on the plaintiff in 1992 and 1993. The patient claimed she later learned the physician was HIV-positive, Morse said. The physician's medical partner, the hospital and the medical plan all declined to respond to her queries about the physician's HIV status.

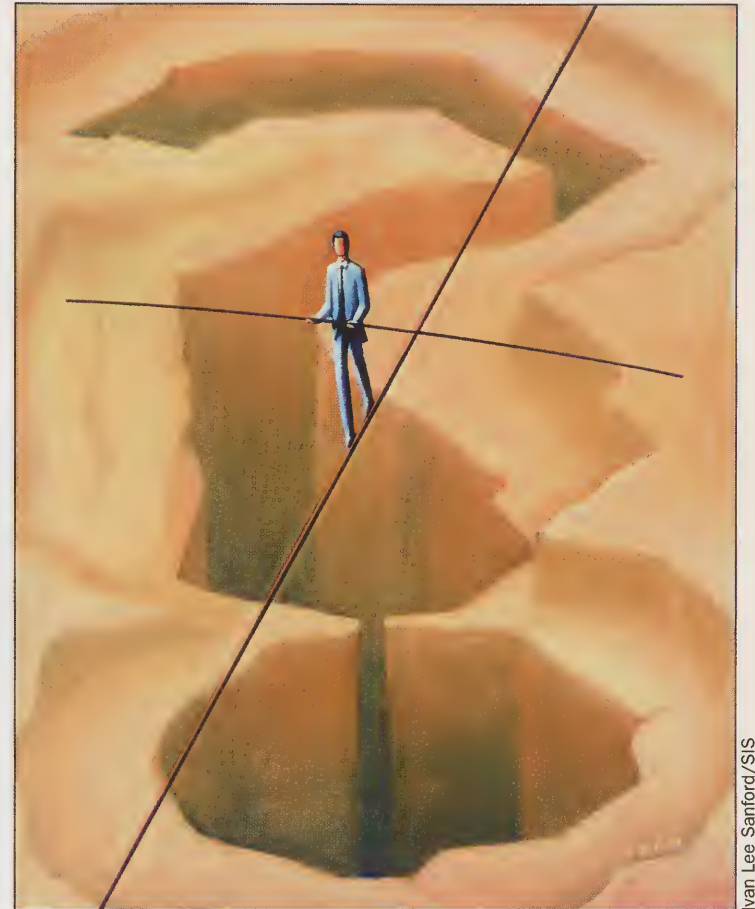
Subsequently, Morse said, the patient brought an 18-count complaint against Dr. Noe, his corporation, his medical partner, the hospital and the health plan, charging them with negligence, battery and intentional

infliction of emotional distress, among other things. All but one of the counts – the one alleging emotional distress – were dismissed by the trial court.

The appellate court later affirmed the trial court's decision, and held that physicians must disclose their HIV status to patients undergoing invasive surgical procedures. If they fail to do so, the court ruled, damages are available covering the window of time during which patients fear they may have acquired HIV, even if they later test negative for the virus.

Morse called this decision "difficult and confusing" for physicians. "This tries to create a new standard of disclosure that says physicians have to disclose their medical conditions to patients, so that patients can decide whether they want to continue to be treated by a particular physician."

Requiring disclosure of HIV status could be only the tip of the iceberg, Morse suggested. "You start out with the issue of HIV, but then there could be incredible efforts, I would guess, to expand that – first and foremost to other sexually



Ivan Lee Sanford/SIS

transmitted diseases. And from there it could move to other communicable diseases," he said.

"Now, I realize this is a far stretch but say, for example, that the physician has the flu, and is in his or her office. [Is the physician] liable for any costs or damages if somebody else catches the flu? Physicians are exposed to viruses every day of

their professional lives. So from a practical standpoint, this creates a new and, I think, burdensome and unnecessary obligation. That's a real concern."

Might the ruling also help pave the way for mandatory HIV testing among physicians? This would not be the first time the issue has been

(Continued on page 11)

Seminar sheds light on malpractice suit process

Physicians struggling with a medical malpractice lawsuit may find themselves under extreme stress. However, an ISMIE seminar can help physicians stand up to the pressures of being a defendant by shedding light on the litigation process.

The seminar – "Taking Control: Managing Your Medical Malpractice Lawsuit" – is open to ISMIE-insured physicians who have been named as defendants in a lawsuit, and to their spouses. This free, two-hour seminar will be conducted May 20 at the University Club in Chicago. Additional seminars will be held Sept. 16 in Quincy, Oct. 7 in Oak Brook and Nov. 4 in Collinsville.

All seminars will begin at 6 p.m. with a 45-minute discussion on the initial phases of the litigation process. It will cover such topics as claims notification, the roles and responsibilities of a defense

team, the discovery process, confidentiality issues and the emotional impact of becoming a defendant.

From there, panelists will discuss the claims management process, obtaining a medical consultant, depositions, factors considered when deciding to settle or defend a case, the effects of the lawsuit on physicians personally and professionally, and the importance of family support during the litigation process.

The seminar will conclude with a review of ISMIE's defense policy and the trial process, as well as a discussion of coping techniques and the long-term effects of litigation on physicians.

Physicians attending the seminar can earn a maximum of two hours of Category 1 credit. For more information or a registration form, call ISMIE at (312) 782-2749 or (800) 782-4767, ext. 1327.

MALPRACTICE ROUNDUP

Parents sue physicians, hospital for miscues in baby's treatment

After several inconclusive visits to physicians and hospitals, a 7-month old boy sustained severe brain damage, leading to a \$3 million judgment in a suit brought by his parents on his behalf.

According to the March 23 issue of the *National Law Journal*, after receiving a prescription for ibuprofen for her son's high fever from a pediatrician who suspected a viral infection – the first of several diagnoses – a California woman took the child home and saw his fever continue to spike over the next four days. She took the baby to another physician who diagnosed bronchitis and prescribed a steroid, also to no avail.

After another day without improvement, the baby's parents took him back to the first pediatrician, who prescribed antibiotics that did not improve his condition. The parents then took the baby to a Palm Springs, Calif., hospital where, following a test for meningitis, he had a seizure that led to nearly 10 hours of uninterrupted seizures. At another hospital, he was given a medication that stopped the seizures. The baby was left with severe, permanent brain damage.

His parents sued the original hospital and the physician who first treated him there, as well as his first treating pediatrician, charging negligence. The hospital-based physician settled for \$600,000. The jury awarded the family \$19.15 million, but the \$17.9 million in economic damages were reduced to the present value of \$2.75 million in compliance with California law. The \$1.25 million in noneconomic damages was capped at \$250,000.

As managed care continues to erupt ...

Physicians' advocate takes center stage

New ISMS President Richard Geline, MD, aims to block the flow of harmful change.

BY LINDA MAE CARLSTONE

In a volcanic health care environment fraught with uncertainty, newly inducted ISMS President Richard Geline, MD, displays a rock-solid stability likely to serve him well during the months ahead.

Dr. Geline, 60, is an orthopedic surgeon in private practice since 1971. Describing his life as free of chaos, Dr. Geline explained, "I've had one job, one wife, one house and lived in one town." His Skokie office has been the base of his private practice "forever," according to Karen Kitze, who, no surprise, has been Dr. Geline's office manager for 24 years.

True to character, Dr. Geline's focus as he steps up to the presidency is not on what he needs to change, but what he needs to preserve: "Doctors cannot lose the ability to deliver top-notch care to the best of their judgment, and to act purely on behalf of patients."

He summed up his primary goal with a rule he learned early in his training. "That patient in the bed is my friend, and I should do everything for him," Dr. Geline said. "It's not any harder than that."

Although the rule may be simple, restrictions imposed by managed care are making it tougher and tougher to follow. "Doctors are taught to analyze situations and act on them. Now managed care enters and says you can't go this way or that way, and suddenly the door is closed. It is driving a wedge through that closeness with a patient."

Therein lies his agenda for the year, uniting physicians to battle the forces of big corporations – an agenda more inherited than invented. "It's not my agenda," Dr. Geline stated. "It's the agenda of the decade. It started before me and will continue afterward." He said his contribution will be to keep the spotlight on the cause. "I hope to show passion for it. Keep it on the front burner. Keep apathy from developing."

Dr. Geline also sees the role of president as an ambassador to draw a wider circle of physicians under the Society's umbrella. "The Medical Society is for all doctors, and I don't want anyone to feel excluded. We face a common set of problems."

Rep. Sara Feigenholtz (D-Chicago) said Dr. Geline has held onto an old-fashioned style, despite

pressures to place economies ahead of patients. "He brings two worlds together in the way he treats his patients," she said. Feigenholtz first met Dr. Geline when she was a child tagging to work with her mother, a former physician at Illinois Masonic Medical Center in Chicago. She became reacquainted with his work when she participated in a mini-internship – an ISMS Alliance program that lets

community leaders shadow physicians during a typical day on the job. "He has a great bedside manner, spends time with his patients and remains invested in their health," she said.

As a lawmaker, Feigenholtz has also come to appreciate his political savvy. "I have talked to him many times about issues that impact directly on my dis-



Richard Geline, MD

trict, the community and the hospital where he practices. I know that he has tenure with ISMS and I ask him to be my messenger."

An ISMS member since 1969, Dr. Geline's heightened involvement in organized medicine started in the early 1980s with a colleague's simple invitation to attend a Chicago Medical Society meeting. One meeting led to many more, said Dr. Geline, whose future in organized medicine was likely carved out long ago by his get-involved attitude.

"I always felt there was a need for doctors to participate in the process, to be more than just practitioners and to do more to control their own destiny," Dr. Geline said. "If you just sit by and practice medicine, the world will change around you without your input."

Certainly, Dr. Geline has not watched from the sidelines. He has held a list of ISMS positions, including being a board member since 1994 and a House of Delegates member since 1988. He has

harge



Dr. Geline confers with patient Randy Gawlik at Illinois Masonic Medical Center.

area be of the highest quality we can produce." Dr. Wehrmacher added that not only is Dr. Geline a hard worker, but he also has a flair for stimulating his colleagues to work hard too.

Physician unity is key to the battle, Dr. Geline believes. An individual doctor going up against an insurance company will be told to take it or leave it, he said. "That gives the Aetnas of the world a big advantage. As HMOs get bigger, we need a corresponding balance on the

professional side or we'll get run over."

Dr. Geline graduated from the University of Wisconsin Medical School in 1962 and did an internship and medical residency in New York City. His private career was interrupted from 1964 to 1966 to serve as a U.S. Air Force captain in Spain. After the service, he moved to Chicago for a residency in orthopedics, a specialty he said fits his personality. "Orthopedics is very tangible; you see the results of your work. It's easy to appreciate because it's concrete."

Although Dr. Geline takes time out for his family, a little tennis and an annual ski trip, many of his other activities revolve around his practice and organized medicine, said Patricia Geline, his wife of 23 years. Even their introduction happened on the job. They met when she was a nurse in the critical care unit at Illinois Masonic Medical Center and he was a doctor on the hospital's medical staff. They married on January 18, 1975. The couple has three children: Sarah, 21; Michael, 19; and Emily, 17.

Together, they lead what they know others might call a predictable lifestyle, but that's the way they like it, both agree. Patricia Geline said she is very excited about her husband taking the helm at ISMS, and she knows the Society is getting a dependable president who is ready to face any challenge. "He's very stable, and he gets the job done." ■

served on the ISMIE governing board and Risk Management Committee since 1989. Since 1982 he has also served in numerous Chicago Medical Society roles, including president of the North Side Branch and chairman of the Ad Hoc Committee on International Medical Graduate Relations.

Dr. Geline's commitment to organized medicine gets high praise from his predecessor as ISMS President, Jane Jackman, MD. "He's extremely hard working," she said. The best evidence of that, Dr. Jackman added, is his willingness, as a solo practitioner, to step in as president. "There's so much time away from your practice with this job," she said. "You are the chief spokesman for the Medical Society. You are obligated to be where they need you."

She predicted a tough year ahead for health care. "There are a lot of depressed and angry doctors out there who feel they can't do the job they want to do," she said. However, Dr. Jackman also anticipated that it will be helpful to have a president from an active practice because the doctors will see he is facing the same problems they face. Dr. Geline is "very high energy, very positive, and those qualities will serve us well," she said.

Longtime friend William Wehrmacher, MD – the colleague who invited him to that first CMS meeting – said he spotted Dr. Geline's leadership potential from the beginning. "He had the right attitude of using the Society to insure that medical care delivered in this

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IDPR DISCIPLINES

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December 1997

Yang Woo Yeom, Chicago – physician and surgeon license placed on indefinite probation and fined \$500 for failing to report to the Department his termination from a state medical assistance program that is seeking to recover overpayment to him.

The following individuals' physician and surgeon licenses were revoked for violating the terms and conditions of a previously ordered Department probation: Chinfong Tsai, Zion; and Baron Von Baucom, Carbondale.

January 1998

Norberto T. Agustin, Oak Park – physician and surgeon license placed on probation for an additional year for violating a previously ordered Department probation.

Mohammed Ali, Willow Brook – physician and surgeon and controlled substance licenses placed on indefinite probation after being terminated from the Medical Assistance Program of the Illinois Department of Public Aid in 1992, and being denied reinstatement in 1994.

Rudolfo Beer, Wood River – physician and surgeon license reprimanded for failing to address a patient's chest pain in an appropriate and timely manner.

Ramon Castro, Oak Park – physician and surgeon license reprimanded and fined \$500 for referring patients to a company owned by his spouse for the purpose of obtaining diagnostic imaging.

Soo I. Cho, Ballwin, Mo. – physician and surgeon license placed on indefinite probation due to outstanding tax liability owed the Illinois Department of Revenue and failure to pay income taxes for 1994 and 1995.

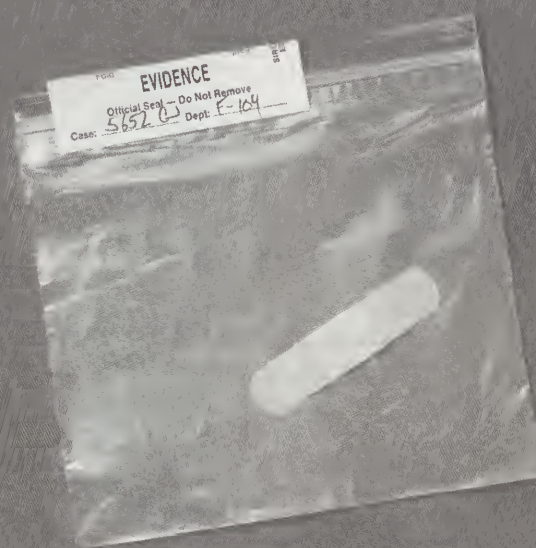
Timothy M. Cullinane, Elmhurst – physician and surgeon license reprimanded and fined \$1,000 for billing a patient for "individual medical psychotherapy" sessions that did not take place.

Robert L. Farner, Toluca – physician and surgeon and controlled substance licenses placed on indefinite probation for violating controlled substance laws and violating regulations on security and recordkeeping.

Richard F. Gallagher, Oak Brook – physician and surgeon and controlled substance licenses suspended for six months for violating the terms and conditions of a previous Department order.

Exhibit A:

Adhesive bandage, which plaintiff alleges defendant pulled rapidly from skin, violently tearing three hairs from plaintiff's arm, which resulted in severe shock, trauma, disfigurement, chronic debilitating pain and permanent psychological damage.



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The St Paul

Medical Services

ISMIE

(Continued from page 7)

raised — when AIDS initially became a public concern, some factions suggested physicians and other health care workers undergo HIV testing. “It was a very emotional response to a difficult situation,” Morse recalled. The suggestion did not prove to be a practical one, however, and has not garnered much support in recent years. *Doe vs. Noe*, however, may revive the issue, Morse acknowledged.

Morse said he is particularly troubled by the fact that three other appellate courts’ decisions in Illinois that have held contrary to *Doe vs. Noe*. In these cases, he observed, the courts have decided no liability exists in a situation in which the patient has not acquired HIV.

“Currently, the law in Illinois basically says if you could not show there was exposure to the disease, then you could not bring a lawsuit,” he said. A 1994 case, for example, involved a patient and a medical technologist who were both pricked with a needle and their blood came in contact with each other. The medical technologist refused to be tested for HIV, and the patient sued for damages because she experienced fear that she had contracted HIV. “The court said, ‘You can’t get damages for a mere fear of getting a disease, you need evidence you were truly exposed,’” Morse said.

Two other related cases are now pending in the Illinois Supreme Court, according to Morse. *Doe vs. Northwestern* concerns patients who had been treated by an HIV-positive dentist; and *Majca vs. Beekil* concerns a patient exposed to blood from a scalpel that had been negligently disposed of by a physician, who later died of AIDS. In both cases, the courts ruled that patients do not need to allege they have been exposed to HIV to recover damages for fear of contracting AIDS. They must prove, however, that they “reasonably feared a substantial medically verifiable possibility of contracting HIV,” a requirement that had not been met in either of the two cases.

The concept of “reasonably feared” is murky at best, Morse said. “We don’t have a good sense of what that means. The courts have stated it must exist, but have not enunciated what that means. It will be developed case-by-case.”

Given such vagaries, Morse said, the current standard of practice in Illinois is also somewhat unclear. “Your obligation as a physician is to exert reasonable care, whatever that means,” he said, noting that the courts have yet to spell out a clear definition of “reasonable care.”

In the context of *Doe vs. Noe*, Morse advised a prudent course of action. “Physicians who are HIV-positive need to make sure they use universal precautions to protect patients and everybody else they come in contact with,” he said. HIV-positive physicians who perform invasive procedures may want to evaluate whether it is appropriate to continue providing those services. Otherwise, he said, “It’s still a little early to be making drastic changes.”

More concrete guidance may prove elusive. “We’ll have to watch this case very closely and see whether the [Illinois] Supreme Court decides to hear it,” Morse said. The odds of that happening are slim, however, as the Supreme Court generally hears less than 10 percent of the cases that come before it, he added. ■

Edgars sending toddler immunization reminders to new parents

[SPRINGFIELD] Gov. Jim and Brenda Edgar announced a new partnership with Hallmark Cards Inc. to send greeting cards that tell new Illinois parents about the importance of immunizing children by age 2.

The cards, donated by Hallmark, are mailed to parents as their infants turn 2 months old. A detachable immunization record will be included in the card, as well as a copy of the recommended vaccinations for toddlers, information on

where to receive free or low-cost immunizations and a greeting from the Edgars. The first cards were mailed in March.

The immunization rate for Illinois children age 2 and younger is 79 percent, according to the most recent data from the U.S. Centers for Disease Control and Prevention. The national goal is to achieve a 90 percent immunization rate for 2-year-olds by 2000.

“Ensuring that children receive the

recommended immunizations by age 2 is the best way to offer them a life free from the effects of serious, yet preventable diseases,” the governor said. “Brenda and I hope this additional effort will provide just one more reminder to parents that their child is counting on them to get all their shots on time.”

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House

(Continued from page 1)

"There's enough flexibility [in the bill] to provide for medical care in a lot of areas in the state where there are few doctors and hospitals, and yet [the bill] still maintains the kind of quality care that we want to ensure that we have in Illinois," said Sen. Doris Karpel (R-Roselle), the lead sponsor of the ISMS-endorsed nurse licensure bill and of the compromise bill. "I think it's a good bill, and I think both sides negotiated in good faith and came up with a good product."

Among the bill's key provisions, Dr. Geline noted, is one that requires APNs to have written collaborative agreements with physicians. The APN may only provide those services generally provided by the collaborating physician. This would allow, for example, nurse midwives to have agreements with physicians who

To be licensed as a nurse midwife, clinical nurse specialist or nurse practitioner, the bill requires an APN to be licensed as a registered nurse, earn a master's degree within 12 months after adoption of final rules or July 1, 2001, whichever is earlier, and receive national certification from the appropriate national certifying body. To maintain their license, APNs will be required to complete 50 hours of continuing education during each two-year licensure cycle.

The bill also gives some nurse practitioners the option to be grandfathered. To do so, however, nurse practitioners

must apply for the status by July 1, 2001, must have completed a post-basic education program and must have been in practice for 10 years.

The nurses have also agreed with ISMS' proposal to create an Advanced Practice Nursing Board, which has the power to review and make recommendations to the Illinois Department of Professional Regulation regarding the licensure and discipline of APNs. The governor is responsible for appointing the nine-member board, which will have four APNs, three physicians and two public members, according to the bill.

S.B. 1585 also requires APNs to

verbally identify themselves as advanced practice nurses, including their specialty, to the patient. It prohibits APNs from using the title "doctor" – even if they have a doctorate degree – or any other term that may indicate to others they are qualified to practice medicine.

"I'm extremely pleased with the bill we've passed over to the House," said Sen. Bradley Burzynski (R-Sycamore), the lead sponsor of a bill proposed by the nurses who has now added his name to the compromise bill. "I really think it reflects the concerns of the Medical Society and the nursing associations, and provides for quality health care." ■

*"I really think
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and the nursing
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health care."*

practice obstetrics, but prevent them from having agreements with physicians who don't practice obstetrics.

As part of the collaboration, physicians will provide medical direction, defined as guidelines and standing orders that are jointly developed and signed by the collaborating physician and APN. Also, nurses have agreed to delegated prescriptive authority for controlled and noncontrolled drugs. The collaborating physician may delegate prescriptive authority for Schedule III, IV and V drugs, but may not delegate authority for Schedule II drugs, according to the bill.

ISMS had requested a ratio that would limit physicians to two collaborative agreements with nurse practitioners, clinical nurse specialists and nurse midwives, and four agreements with nurse anaesthetists. However, senators and nurses expressed deep concern about the ratios with some senators pointing out that only three states now have ratios and that Arkansas recently repealed its ratios. The lawmakers subsequently asked for an acceptable alternative to strict ratios that would still prevent abuses.

To preclude physicians from entering into an excessive number of agreements to the detriment of patients, the compromise bill states the collaborating physician must be in an active clinical practice and also adds two grounds for discipline to the Medical Practice Act. The first would allow the Illinois Department of Professional Regulation to discipline physicians who enter into too many written collaborative agreements with APNs, preventing them from adequately collaborating and providing medical direction. The second ground would allow a physician to be disciplined for repeatedly failing to adequately collaborate with or provide medical direction to an APN.

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Compliance

(Continued from page 1)

compliance plan. "The essence of a compliance plan is that physicians or groups of physicians make a commitment that they and everyone else in their organization will comply with the law," explained John Schneider, MD, chairman of ISMS' Third Party Payment Processes Committee. A clear commitment to compliance is one of the seven vital elements in any compliance plan, according to the AMA's guidelines.

The other six elements are: the appointment of a trustworthy compliance officer with a high level of responsibility; effective training and education programs; auditing and monitoring; communication; internal investigation and enforcement; and response to identified offenses and application of corrective action initiatives. Intertwined with all of these elements is the need for accurate documentation.

Each one of these elements is described in the AMA's guidelines, said AMA President Percy Wootton, MD, and each one should be tailored to fit the needs of a physician's practice. For

example, to fulfill the internal investigation and enforcement element, Dr. Wootton said he conducts occasional self-audits in his cardiology group practice. He will request the records of every other Medicare patient for the last three days or so, and then review the file to ensure the coding on the bill is the same coding he provided documentation for in a patient's records. A solo physician, however, may have different needs and resources than a physician in a group practice, he said.

The existence of an effective compliance plan demonstrates to government officials that a physician's intent is to follow the law, not circumvent it, an AMA spokesperson said. As Dr. Schneider explained, "If there is an inadvertent error, your best defense is to be able to say, 'Yes, I know these rules are out there, and I'm doing the best I can to make sure that everything done in my office is in compliance. I'm sorry. I guess I sort of goofed on this one.'"

The government has acknowledged that it looks at internal efforts to fight fraud. "When fraud is discovered, both the Department of Justice and [the

Office of the Inspector General] look at the entity to see if reasonable efforts have been made by management to avoid and detect any misbehavior that occurs within their operations," said Inspector General June Gibbs Brown in an open letter to health care providers. "We use this analysis to determine the level of sanctions, penalties and exclusions that will be imposed upon the providers."

Although the seven elements and the need for documentation are included in all compliance plans, simply putting a compliance plan on paper isn't enough; physicians need to follow through on implementing the plan, the AMA spokesperson said. Failure to implement an existing, written plan could be used as evidence that perhaps someone knew fraud occurred and, despite that knowledge, took no action to resolve the problem, the spokesperson said.

The current flux in government antifraud and anti-abuse regulations shouldn't deter physicians from implementing plans in their offices, Dr. Wootton said. Some antifraud regulations, like the Stark law, have been in place for a while. Compliance with other regulations, such as those issued by the Occupational Safety and Health Administration, can also be monitored with a plan.

The AMA released its compliance plan guidelines, Dr. Wootton explained, "to try to help physicians prove that they are living not only by the exact letter of the law, but also by the spirit of the law." Fraud is out there, he said, and it's been documented in the media and elsewhere. The AMA doesn't tolerate it, he said, "but the vast majority of physicians are honest, law-abiding citizens who should be treated just like everyone else — innocent until proven guilty."

For a copy of the AMA's compliance plan guidelines, call the AMA at (312) 464-4867. Physicians can call the AMA's Consulting Link at (800) 366-6968 to find a consultant or attorney who can help tailor a compliance plan to the needs of a particular practice. ■

Court ruling

(Continued from page 1)

Cross Blue Shield. If it goes through, the merger will provide greater financial stability and economies, said Tony Rau, spokesperson for Blue Cross Blue Shield of Illinois. Together, they will realize savings from workers doing things in tandem, and will enjoy greater resources to meet competition down the road, he said. Policyholders in both states will benefit from reduced costs and lowered premiums, he added.

The merger is not unique, but actually part of a reorganization trend by Blues plans responding to local competitive pressures by forming alliances and partnerships with fellow Blues, according to Chris Martin, spokesperson for the Blue Cross Blue Shield Association, which represents independent BCBS plans. In the past, most mergers or alliances in the Blues system involved combining multiple plans in one state. But in the last few years the number of Blues business combinations crossing state lines increased dramatically. For example, Colorado and Nevada Blues plans merged in 1996, as did plans in Iowa and South Dakota.

The attorney general's antimerger arguments centered on a Texas law that prohibits nonprofit corporations from merging with entities other than those specifically allowed by the Texas Nonprofit Corporation Act, according to Sonya Sanchez, spokesperson for the attorney general. The Texas plan is a charitable company, she said, and the Illinois plan does not meet the definition of a nonprofit corporation, according to the suit.

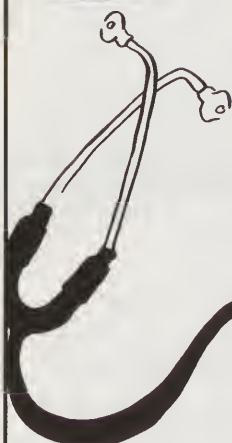
The danger in the merger, according to the attorney general, is that it would siphon hundreds of millions of charitable dollars from Texas.

"It's the attorney general's job to protect the interest of Texans in a charitable trust," Sanchez said. "When the public donates to charitable purposes, the money is supposed to be used for charitable funds. Under the merger, the Texas company will no longer exist, and control of the nonprofit corporation's assets will be subject to Illinois laws. Even though Blue Cross Blue Shield of Illinois is a nonprofit mutual insurance company, it would only require a vote of its board of directors to become a for-profit entity," she said.

Judge Joseph Hart, 126th District Court, disagreed in his ruling that BCBST is a charity. "It operates only for the benefit of its policyholders, not the public at large," the ruling states. "It charges market, competitive prices for its product." The ruling is in the form of a letter, and the final judgment is yet to be issued. BCBST was asked in the letter to draft an actual judgment in line with the letter and submit it for approval.

The attorney general is waiting for the final judgment to be released before deciding whether to appeal the decision, Sanchez said. Once the judgment is in place, he has 30 days to appeal. If no appeal is made, the next steps toward approval of the merger would be reviews by the federal government and insurance regulatory agencies in both states, and votes by both plans' boards of directors. Upon approval of the two plans, the parent company would become Health Care Service Corp. Based on the size of each plan, the HCSC board would be comprised of 10 members from Illinois and six members from Texas. ■

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Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • MAY 15 1998

Medicaid managed care put on hold

PAGE 2

Delegates demand AMA accountability

ACTION: Physician disenchantment sparks study.

BY LINDA MAE CARLSTONE

[OAK BROOK] Responding to members' growing dissatisfaction with the American Medical Association, ISMS leaders will take a long, hard look at breaking the linked membership the two groups now share.

The ISMS House of Delegates, at its 1998 Annual Meeting held recently in Oak Brook, approved formation of a special ISMS committee of the House that will assemble to conduct an in-depth study of deunification. The committee, to be appointed by the speaker and vice speaker, will report back to the House at either the 1999 Annual Meeting or a special meeting called for that purpose.

Taking the study route was actually a compromise response to a push at the Annual Meeting for ISMS to sever its joined membership ties. "The current policy is not working," stated David Harmon, MD, a delegate representing the 14-member Jersey-Calhoun County Medical Society, whose members want to deunify. "We need to send a different message to the AMA," said Dr. Harmon, who after the Annual Meeting called the AMA an unresponsive organization that doesn't have any contact with the needs of grass-roots physicians.

Richard Frederick, MD, a delegate representing Tazewell County, said he got "strong marching orders in favor of deunification," from

(Continued on page 12)



STAY OR GO? Tazewell County Delegate Richard Frederick, MD, (top left) revealed "marching orders" given him by those he represents about the Society's future with the AMA. Waiting to share their views are ISMS Trustees Robert Hamilton, MD, of Alton, (center) and Erlo Roth, MD, of Hinsdale (right).

CHAMPAIGN COUNTY Delegate Elizabeth Campbell, MD, (at left) listens intently as the House debates hot topics at the ISMS Annual Meeting held last month in Oak Brook.

REFERENCE COMMITTEE B Chairman Shastri Swaminathan, MD, (below), and Sangamon County Delegate Craig Backs, MD, (bottom) weigh in on the discussion on E&M guidelines, the source of much physician ire.



Photos by John McNulty

Medical Society drives rollback of E&M guidelines

MESSAGE RECEIVED: Grass-roots anger triggers another delay; rewrite in the works. BY JANE ZENTMYER

[CHICAGO] After months of pressure from ISMS that physicians need simplified and voluntary E&M documentation guidelines, the U.S. Health Care Financing Administration appears to have finally gotten the message. On April 27, agency officials announced that the guidelines will be delayed pending a rewrite.

The announcement follows strong protests from the Society to HCFA, the state's Medicare carrier, and others that the guidelines are inherently flawed. Key problems include that the guidelines impose criminal penalties on physicians for failure to comply and create an administrative hassle that eliminates time physicians can spend on patient care. Some physicians have described themselves

as "livid" and "incensed" about the 1997 guidelines, which they condemned as "bureaucratic nonsense."

The recent ISMS House of Delegates Annual Meeting served as an outlet for the groundswell of grass-roots anger at the documentation guidelines. The American Medical Association came under fire for its work in developing the guidelines jointly with HCFA. "The AMA didn't do this for us," said Craig Backs, MD, a Sangamon County delegate. "They participated in doing this to us."

Dr. Backs wrote one of seven resolutions demanding action from organized medicine on E&M coding documentation. Delegates unanimously adopted a single resolution consolidating the underlying message of all

seven: "ISMS opposes the implementation of the current unworkable E&M guidelines and urges HCFA to develop appropriate, rational and voluntary guidelines for documenting E&M services."

By passing the resolution, the House directed the Society to tell the Illinois congressional delegation that physicians need legislative relief from fraud and abuse penalties, such as prosecuting

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Look for your upcoming ISMS survey

ISMS wants to know what's on your mind: AMA deunification, difficult managed care contracts, intrusive regulations, risk management issues? A survey will be mailed to ISMS members within a few weeks. Take a few moments when you receive it and let us know how the Society can help you.

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Medicaid managed care put on hold for at least a year

CHANGES: State will emphasize the options recipients now have.

BY LINDA MAE CARLSTONE

[SPRINGFIELD] Illinois has sidelined, at least temporarily, the MediPlan Plus program that would move Medicaid recipients into managed care, opting to concentrate on a health care choice initiative instead.

For the most part, the hold on MediPlan Plus is due to the pending change in Illinois' governor, according to George Hovanec, Illinois Department of Public Aid administrator of the division of medical services. "We didn't want to start such a large undertaking with a definite change in leadership coming," he said, adding that it made sense to wait a year rather than hand the new governor a partially implemented program.

In place of MediPlan Plus, the department has launched a Responsible Choice counseling program, expected to better educate Medicaid recipients about managed care options. The program ties health benefits counseling into the regular needs-assessment sessions used by caseworkers to help recipients develop an employment plan, according to Gwen Smith, manager in the IDPA policy and operations section of the managed care bureau.

Following caseworker meetings, Medicaid clients will meet with a Health Benefits Representative who will inform recipients about the differences between regular Medicaid health coverage – the term used to describe fee-for-service – and managed care. The fee-for-service label is avoided because it can mislead clients into believing they must pay a fee, when in reality they do not, Smith said.

"We talk to them about having a medical home, and about their health care rights and responsibilities," Smith said of the health benefits counseling, in which patients are asked to make a choice between the two health insurance programs. In the past, health care counseling was optional, Smith pointed out. "Caseworkers would ask clients if they wanted to hear about their choices, but it wasn't strongly encouraged."

Health benefits representatives will now be near caseworkers in offices in order to facilitate the expanded collaboration. Smith explained that in the past they have always worked in the same building as the caseworkers, but not in such close proximity.

The new initiative stops far short of the sidelined MediPlan Plus program, which would have assigned managed care plans to recipients failing to choose a provider. Under Responsible Choice, managed care is strictly voluntary. "We get them to understand they have a choice, that they need to take responsibility for making a choice," Smith said.

Although MediPlan Plus was designed in part to control costs through increased enrollments in managed care, Hovanec said that even without its implementation the Medicaid budget is in good shape because of cost controls implemented the past several years.

The Responsible Choice initiative is accompanied by an expansion of managed care program availability – both in

eligibility and geography. The pool of potential new clients statewide is estimated at 531,140. The increase in the number of those eligible is due partly to an extension of Medicaid coverage for up to 12 months now made available to clients losing financial assistance when they get a job.

The biggest impact on physicians is expected in some downstate regions, including Decatur, Peoria, Champaign and Bloomington, where managed care is just beginning, according to Hovanec. IDPA is lining up contracts that will establish a managed care option in the southern half of the state within six months, he said. The new managed care contractors are in the process of soliciting more physicians to join their networks. Managed care has been a choice for Cook County Medicaid recipients since 1974, and is now at a 50 percent saturation in the county.

Because the choice is not mandatory, the impact on physicians from an increase in Medicaid managed care will likely not happen for more than a year, Hovanec said. "Our experience is that HMOs start slowly," he added.

Another reason the start-up could be slow is that there are no direct financial incentives to choose managed care, because patients on regular Medicaid do not pay fees. Many recipients may not see an advantage, he said.

As for the future of MediPlan Plus, that will be determined by the next governor, Hovanec said. In the meantime, the federal government has received the details of Illinois' MediPlan Plus plan. "They will be instructed that the state would like another year to implement it," he said. "That way, if the next governor wants to implement it, he will be free to do that."



John McNulty

DR. GELINE (left) smiles as outgoing ISMS President Jane Jackman, MD, adjusts the president's medal during his installation April 26. Physicians today face the pressure of the "experiment of managed care" that has many faces, and lurches from phase to phase and from plan to plan at the expense of patients, Dr. Geline told the 1998 House of Delegates. "The public has taken note and is balking at restrictive systems which limit access to the doctor of their choice."

Geline, Callan selected as top Society officers for 1998-99

[OAK BROOK] Clair Callan, MD, was selected as president-elect April 26 at the ISMS House of Delegates Annual Meeting in Oak Brook. A Lake County anesthesiologist, Dr. Callan is vice president of the hospital products division, medical regulatory affairs and advanced research for Abbott Laboratories in Abbott Park. Skokie orthopedic surgeon Richard Geline, MD, was installed as president during the meeting.

Other new officers are: Chicago internist Joseph Murphy, MD, as first vice president; Moline cardiologist Richard Snodgrass, MD, as second vice president; and Chicago internist Janis Orłowski, MD, as secretary-treasurer. Chicago internist John Schneider, MD, will return in 1999 as the speaker of the House, and Rockford family physician

William Kobler, MD, will again serve as vice speaker of the House.

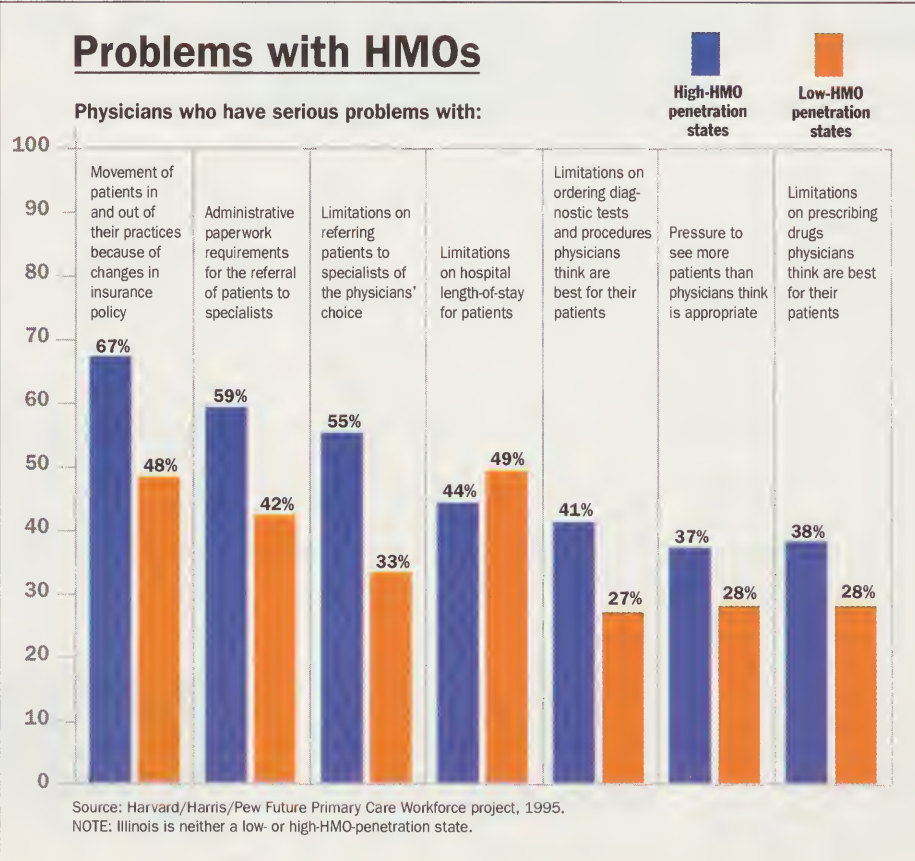
In addition, the delegates elected several members to the ISMS Board of Trustees, which will be served by Arthur Traugott, MD, as the new chairman of the board.

Albino Bismonte Jr., MD, of Gurnee, was re-elected to represent the First District; Theodore Kanellakes, MD, of Joliet, was elected Second District trustee; Edmund Donoghue Jr., MD, of Chicago, and Kenneth Printen, MD, of Evanston, were re-elected Third District trustees; and Raj Lal, MD, of Lombard, was elected Third District trustee.

Others elected were: Sandra Olson, MD, of Chicago, Third District trustee; Ronald Ruecker, MD, of Decatur, Seventh District trustee; Richard Bulger, MD, of Hinsdale, Eleventh District trustee; and Dennis Norem, MD, of Rockford, Twelfth District trustee.

Robert Oliver, MD, of Springfield, was re-elected by the Resident Physicians Section to be the Section's representative to the ISMS Board of Trustees. In addition, Darcey Bittner of Chicago was named as the Medical Student Section representative to the board.

The 1998 House of Delegates also elected its delegates and alternate delegates to the AMA House of Delegates during the ISMS House meeting in Oak Brook April 26.



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Supreme Court bars contingency-fee expert witnesses

DECISION: Payment method violates public policy. BY JANE ZENTMYER

[SPRINGFIELD] In medical malpractice litigation, the jury is supposed to rely on an expert's honest opinion as it works toward a verdict. However, when experts are paid with a contingency fee, they have an incentive to color their testimony because their fee may increase with the lawsuit's verdict. But a recent Illinois Supreme Court decision reaffirmed decisions from more than 100 years ago that ban contingency fees.

In December, a unanimous court determined that this contingency fee arrangement still violates the state's public policy, a legal standard the court uses to examine issues such as health, public morals and safety. Justice Benjamin Miller wrote, "We believe that the same evils identified by the court many years ago ... [still] operate here."

The case, First National Bank of Springfield vs. Malpractice Research Inc., stemmed from a medical malpractice lawsuit filed in a Montgomery County court on behalf of a child for injuries she sustained during birth. (First National Bank is the guardian of the child's estate.) The plaintiffs signed a contract with Malpractice Research, a Virginia business owned by a physician, that stipulated the company must seek and supply expert witnesses, as well as provide other assistance related to trial preparation.

As payment for its services, the company would receive 20 percent of any settlement or judgment as a contingency fee, according to the court. However, any expert witnesses retained by the company would be paid flat fees; in other words, their fees would not be based on the settlement or judgment.

During the legal proceedings, however, the plaintiffs retained a new attorney who didn't use the services of Malpractice Research, according to the court. When the case settled for \$500,000, the company sought its 20 percent share, or \$100,000. The plaintiffs then asked the court to determine their obligations under the signed contract.

The Supreme Court's decision against paying contingency fees to expert witnesses resolved conflicting decisions from the appellate and circuit courts. "The court seems to say that it's hypocritical to be an expert witness and yet have your compensation based on the outcome of the case," ISMS General Counsel Saul Morse said.

An expert witness who receives a flat fee is presumed to offer the same testimony regardless of the outcome of the case, Morse explained. However, "if you pay the expert \$500, but say, 'Look, I'll pay you an extra \$500 if your testimony helps win the case,' it acts as an inducement for the witness to think, 'Well, I'd like to make more so maybe I'll add a little emphasis in my opinion or color my testimony,'" he said.

That is not the intended role of an expert witness, Morse said. "Expert witnesses are called experts because they are considered to have some unique knowledge or experience that lets an attorney go to a jury and say, 'You should pay special heed to these people,'" he said. "The jury is supposed to rely on these people not only to be honest, but also to state

their opinions as experts in the field."

The Supreme Court said that the company's arrangement to pay a flat fee to the expert witnesses it retained also violated the state's public policy. "A witness finder of the type used in this case has [an] incentive to locate a person who will maximize the finder's own recovery and not simply serve as a reliable witness," according to the court's opinion.

As further support that arrangements

like this one violate the state's public policy, the Supreme Court cited an ethics opinion from the Illinois State Bar Association, which submitted an amicus brief in support of the plaintiffs. The legal profession's Rules of Professional Conduct prohibit paying a contingency fee directly to a witness, the court noted in its opinion. The ISBA examined whether an attorney could recommend that a client contract with a witness finder and

pay for the service with a contingency fee. "The bar committee concluded that the arrangement was an invalid attempt to circumvent the rule barring the payment of contingent fees to expert witnesses," the court said.

In its opinion, the court made a distinction between the contingency fees paid to attorneys and the contingency fees paid to witness finders. The court noted, "Unlike attorneys, who may be paid on a contingent-fee basis, witness finders operate outside the supervision of the courts and are not restricted by any ethical or statutory limitations on the amounts of their fees." ■



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REPORT for Illinois Physicians

CARE-VALUE PATHWAYS:

Last month's "Report" described the care-value pathway development process. The first of the pathways is presented below. Additional pathways will be published in subsequent "Reports".

CARE-VALUE PATHWAYS: ANGINA PECTORIS

Eligibility: Patients with chest pain (or anginal equivalent) suspected of having angina pectoris.

Admission criteria: All such patients should be admitted for observation when the history suggests true angina pectoris, and in selected cases of atypical chest pain.

Optimal Length of Stay: 1 day

Day 1

Acute myocardial infarction is ruled-out/ Low-risk patients have very low probability of death in short-term follow-up study/ Early discharge with outpatient work-up of such patients is generally safe. Characteristics of low-risk patients include:

- absence of severe, prolonged or rest episodes of anginal pain
- absence of prior known Coronary Artery Disease
- ST depressions on EKG are not significant (<0.5 mm)

Stress test is scheduled for the next am, when not low-risk, or the patient is discharged after a 1-day stay when low-risk.

High risk patients are notable for anginal pain associated with:

- prolonged typical angina of greater than or = 20 minutes
- pulmonary edema
- new mitral regurgitation murmur
- hypotension
- pain associated with new significant ST or T-wave changes

Note: Optimal LOS for patients who rule-in for an acute MI is currently 4 days. In patients with confirmed coronary disease, aspirin, dietary changes, & smoking cessation should be followed-up with our Secondary Prevention of CAD protocol, with Home Health/Office visits.

Discharge criteria: Patient can ambulate to the elevator without impressive chest pain.

References:

- 1) Agency for Health Care Policy & Research, Clinical Practice Guidelines, #10, Unstable Angina: Diagnosis & Management, 1994, Bethesda: US Dept. Of Health & Human Services
- 2) J-M Gaspoz, et. al., Outcome of patients admitted to a new short-stay unit to "Rule-out" myocardial infarction, *Amer J. Cardiol* (1991) 68: 145-49
- 3) Smith SC, et. al., Preventing heart attack and death in patients with coronary disease, American Heart Association, Medical Consensus Panel Statement, *Circulation* (1995) 92: 2-4

Any comments concerning this pathway should be referred to Prentiss Taylor, MD, Blue Cross Blue Shield of Illinois, 300 East Randolph, 24th Floor, Chicago, Illinois, 60601.

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EDITORIAL

Access to sterile needles

When the ISMS House of Delegates recently improved upon its policy that encourages the distribution of free, sterile needles, this move flew in the face of the Clinton White House – but agreed with points made by David Satcher, MD, the new U.S. surgeon general.

The Clinton Administration believes government-funded exchange programs to buy needles for drug addicts sends the wrong message, and refuses to provide federal funding for them. However, this is an issue of mortality, not morality. Distributing clean needles to drug users helps curb the spread of deadly viruses, a goal to be heartily applauded.

Several ISMS and American Medical Association committees and councils have carefully studied the goals and effects of needle distribution programs. Groups including the ISMS Council on Medical Service, the ISMS Council on Mental Health and Addiction, and the ISMS Ad Hoc Committee on Needle Access have concluded that the distribution of needles will not increase the rate of drug use as some critics have charged – the distribution will decrease the spread of the various strains of hepatitis, HIV and other bloodborne pathogens among people who had been using dirty needles.

In fact, recent data from the U.S. Centers for Disease Control and Prevention indicates that shared intravenous needles are responsible for almost 41 percent of

all new HIV transmission and that about 11,000 new cases of HIV infection could be prevented through programs offering direct access to clean needles and syringes throughout the country.

ISMS delegates first endorsed the concept of needle exchange programs in 1995 as a useful way to curb the spread of HIV when combined with educational and preventive efforts and when done in cooperation with local law enforcement agencies.

Last month, the ISMS House took the policy several steps further by including other mechanisms for sterile needle distribution – programs outside the scope of needle exchange programs. The 1998 policy also recognizes that such programs help prevent other blood-borne diseases beyond HIV, including Hepatitis B and Hepatitis C. The amended policy also states that needle distribution programs must include some mechanism for the proper disposal of dirty needles.

Dr. Satcher said that the Clinton Administration's ban on federal money for such programs makes it even more important for communities to develop and pay for their own distribution systems. ISMS has taken this a little further and has endorsed state-funded sterile needle distribution programs. The ISMS House policies amended in April represent sound public health, and efforts to fund sterile needle distribution centers deserve support.

PRESIDENT'S LETTER

Where is your 'line in the sand'?

Richard A. Geline, MD



"Bit by bit, physicians are finding ourselves less in charge."

In 1990, following the invasion of Kuwait by the forces of Saddam Hussein, then President George Bush drew his now-famous line in the sand and told the Iraqis they could not take one step over it. The line meant complete, prompt withdrawal from Kuwait – not partial, prolonged or delayed withdrawal. The rest is history.

As our health care delivery system evolves, a different and much less direct invasion is occurring, and it's not land or oil that's being taken, but rather the essence of our existence as professionals. We are gradually losing control of our ability to think and act in accordance with our history, our backgrounds and our traditions as physicians that were all designed to serve the best interests of our patients. Bit by bit, physicians are finding ourselves less in charge and more subject to external forces developed by groups responsible, not for patient care, but for outside agendas.

We are gradually coming to recognize that there is a line in the sand beyond which managed care cannot cross without expecting resistance. Each of us will have our own idea of where that line is, what form it takes and how to react to its presence.

To me, the American Medical Association's Report 3 of the Council on Ethical and Judicial Affairs, presented during the 1997 Annual Meeting, gives a thoughtful and sensible approach to placement of the line. Discussing how to combine the restrictions of managed care with patient-first behavior, the report describes some major principles, which, when enacted, should distance the physician from financial performance and permit the physician to think of the patient without regard to the immediate financial impact in one or another area. The principles are:

- A physician's primary responsibility is to the health of patients and to the principles of ethical practice. While physicians have an obligation to consider the needs of the broader patient populations

they serve, their first duty must be to the individual patients they treat.

- Physicians must evaluate the incentive programs that health plans offer prior to signing any agreements with them. They should consider potential conflicts of interest between clinical objectivity and patient advocacy, and the promise of large financial rewards.

- Enough money must be provided to insure necessary services are delivered. But the question "How much is enough?" will remain.

- Subscriber enrollment must be large enough that risk is spread along a broad base and that the adverse experience of any one individual cannot substantially affect the performance of a plan.

- Physicians must have stop-loss insurance. A catastrophic occurrence can occur at any time and to any patient. In order to minimize this impact, an overall performance provision should be made in advance to handle an extraordinarily adverse experience when and if it develops.

- Finally, patients must be given adequate information about the plans in which they are enrolled, as well as the incentives the physicians have been offered. An understanding exists among both physicians and patients that managed care is different, and expectations must be revised accordingly.

These points are elementary in the grand scope of the effects that managed care will have on our day-to-day practice. But by carefully considering each one, physicians can distance themselves from their actual financial performances, and see that the impact of practice on a day-to-day basis does not directly affect overall plan performance. Thus, physicians can focus on patient care in keeping with our history and our charge as physicians.

Where is your "line in the sand"? I expect some of our colleagues will view these ideas as too permissive, while others will view the principles as too restrictive. Most certainly, however, the debate will continue. Please share your thoughts so that together we can continue to address the problems of our time.

GUEST EDITORIAL

Physicians play key role in early intervention services

By Mary Miller

It has long been known that young children experience the highest percentage of physical and cognitive development within the first few years of life. Every child develops at his or her own rate. However, it is also well-known how important it is to recognize when a child's behavior may indicate a more serious disability or developmental delay. Everyone who interacts with youngsters on a consistent basis plays an important role in recognizing and reporting a child with suspected delays.

Physicians are in an especially unique position because parents, who may not recognize a possible delay, will listen to their trusted advice to seek out early intervention services.

Under the federal Individuals with Disabilities Education Act, Part H Early Intervention services – including physical therapy, occupational therapy, nutrition services, speech and language pathology, and vision and hearing services – are available for all eligible children. Early intervention services are designed to help these children get the earliest possible start on overcoming delays that, if not addressed, could lead to more serious problems later in life.

Illinois' Part H Early Intervention services system, once under the leadership of the Illinois State Board of Education, now joins a variety of other early childhood health and prevention programs assumed by the new Illinois Department of Human Services. This will encourage links to programs such as Women, Infants and Children, family case management, high-risk infant follow-up, child care and others.

Because of physicians' unique involvement with families, the state relies on them to help identify children with special needs. In fact, early intervention services are so critical that federal law requires health care and child care professionals to refer children suspected of having delays or disabilities to the system within two working days. IDHS also recognizes that this two-day federal mandate is difficult and can be unattainable for some professionals working with youngsters.

Advocates who have been working on this system for a long time are thrilled that Part H Early Intervention has become more streamlined to serve Illinois

families as efficiently as possible. The statewide system has been reorganized into 24 regional Child and Family Connections agencies that link eligible families to developmental screenings and evaluations for children under 3 years old who exhibit delayed behavior free of charge. An individualized plan then is developed for the family that lists services and supports available for an eligible child.

Fees for services are assessed based on parents' ability to pay, and are often covered under Medicaid and private insurance plans. Parents have a choice whether or not to enter an eligible child into the early intervention services system, but they should keep in mind that the system exists for one reason: to serve the best interest of the child and to provide support for the family.

Hundreds of studies have been conducted over the past 10 years examining early childhood development in a variety of settings. While each study has its own set of specific conclusions, one finding continues to repeat itself: the earlier disabilities or delays are detected, the better the chance a child's needs can be addressed.

Physicians interested in learning more about the Part H Early Intervention Program are encouraged to call (800) 323-GROW if they know of a child who may benefit from receiving developmental screenings. After all, your intervention may make a life-long difference to a child.

Miller is chief of the IDHS Bureau of Part H Early Intervention.



Thanks again for everything, Ray

For some members of the ISMS House of Delegates, the Annual Meeting will never be the same.

Friends, family and colleagues rose to their feet as Nancy Hoffmann accepted a special ISMS physician medical service award honoring her late husband, Raymond Hoffmann, MD, April 25.

Dr. Hoffmann, a general surgeon from Rockford, died July 23, leaving a legacy of professionalism and commitment to his fellow Medical Society members. A past ISMS president and former speaker of the House, Dr. Hoffmann had been a member for 21 years. Immediate past-president Jane Jackman, MD, told delegates that he will always be remembered for his warmth, dedication and humor.

"Outside of the operating room, the House of Dele-

gates was Ray's favorite place to be professionally," Mrs. Hoffmann said as she accepted the award. "He loved being speaker."



MRS. HOFFMANN (left) tells the 1998 House of Delegates that her late husband loved the House more than nearly anything else professionally. Daughter-in-law Michelle and son Nathan listen.

John McNulty

LETTERS

Objects to language in recent advertisement

As president of the Chicago Society of Plastic Surgery, I take significant exception to the Midwest Visual Communications ad in the April 3, 1998, edition of Illinois Medicine. The ad states that the use of leeches constitutes primitive practice. I hasten to inform all our readers, including our technical advertising media, that there is still a very significant place for leech therapy in the practice of plastic, hand and microsurgical procedures. Finger and ear replants have

survived because of the unique characteristic of these lowly creatures.

I would advise any of our non-medical brethren to thoroughly research their topic before denigrating any medical treatments.

Gabriel Mooney, MD, Oak Lawn

Editor's note: Midwest Visual Communications has apologized for inadvertently offending anyone and has decided not to run the advertisement again.

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Coming soon:
Case in Point
on laparoscopy

ISMIE Update

Breaking up is hard to do: contract liability issues

BY CHRIS PETRAKOS

While most physicians expect a certain amount of frustration and difficulty in dealing with insurance companies, there sometimes comes a point at which it makes more financial sense to get out of the arrangement than to hang around until the contract expires.

According to Jim Christman, an attorney at Wildman, Harrold, Allen and Dixon in Chicago, the typical reasons for wanting to get out of a contract are either nonpayment or low payment. "I had a case a while back in which an independent physician organization needed to get out of a contract. The payer was making all kinds of deductions from capitation that were not justified, and the IPO's cash flow was suffering, so they terminated it because they weren't getting the money to pay their doctors. In another situation I had, all the specialists were on a one-year contract, and the PHO said they were going to cut their reimbursement from 105 percent to 85 percent. So the physicians had to decide whether they were going to accept that."

According to most insurance contractors, key definitions can be altered at the discretion of the plan, which means that sudden changes in the way business is done can be an unfortunate fact of life for physicians. Along with

payment problems, some physicians become unhappy with unreasonable denials for treatment from the plan or lower levels of service.

Physicians have to look at how getting out of a contract will affect them financially. Christman added that physicians don't want to lose reimbursement, but they don't want to lose patients either. "I had a meeting at a hospital a few weeks ago, and it was interesting because this situation came up, and some doctors were saying, 'Only 3 percent of my patients are from here so I'm getting out,' but a lot of other physicians were saying, 'Fifty percent of my patients are from here, so I'm going to have to live with the reduction in reimbursement.'"

Judee Gallagher, a Chicago attorney who specializes in managed care contracts, said that physicians can also lessen the impact of termination by doing some savvy negotiating before they sign. "If you're being paid on a capitation basis, it's very important that the contract provide that any care you are required to provide after the termination date be



*"Sudden changes
can be an
unfortunate fact
of life for
physicians."*

compensated for on a fee-for-service basis. Capitation only works if you have enough healthy members on your panel to spread the risk of providing care to your sick patients ... who will not be able to transfer as quickly. If you're left providing care to only the sickest members, it can be financially disastrous."

The transfer of patients at a contract's end needs careful attention, Gallagher said. If the physician is paid on a capitation basis, the contract should specify that the plan will not transfer members to a new provider until the effective date of termination. "This is another way doctors can get hurt.

Let's suppose it's a six-month notice of termination. If those members are actually transferred before the termination date, the physician's patient panel can dwindle, and once again it will be the healthy people who transfer the quickest – not the unhealthy ones. And the doctor will be left with only sick people on his or her panel."

Physicians must also be aware that they are often required to provide care after the date of termination in many capitation contracts – not only to hospitalized members, but also to the members of any employer group until the expiration of the employer group contract. Gallagher said, "I had a group that terminated its contract on March 31, 1998. But in reality they will continue to provide care to members of

that HMO until March 1999, because of the rollover of the employer group contracts. When you negotiate these agreements, you have to be aware of this provision. So this also makes it very important that your compensation for the care you provide after the date of termination is viable." Some contracts can be negotiated so that the physician will not be required to care for members after six months or another set date, Gallagher said.

Finally, there is the matter of indemnification clauses and the transfer of patient records. When physicians sign a contract that contains an indemnification clause, it usually states that the employer will be held harmless in the event of a lawsuit. However, the contract may require the physician, not the managed care organization, to pay all the legal costs of such suits. Gallagher advises physicians to simply strike out such clauses.

Still another consideration when terminating a contract is the transfer of patient records. Physicians should know what kinds of records need to be transferred and who will pay for the transfer. If the issue is not covered in the contract, physicians will need to work out an agreement with the managed care organization after the notice of termination. ■

Illustration by Jude Maceren/SIS

MALPRACTICE ROUNDUP

Failed calf implants lead to leg amputation

A New York man received a \$2.5 million settlement after claiming that two surgeons were negligent in performing silicone calf-implant surgery and diagnosing the subsequent compartment syndrome leading to a leg amputation, according to the March issue of Medical Malpractice Law & Strategy.

According to Fricchione vs. Jacobs, the patient developed complications, including a diminished pulse in his right leg, after the implants were placed. His condition continued to deteriorate and the implants were removed a week later, leaving a complete absence of a pulse in the right leg.

The patient claimed that the physician asked for a vascular consultation when it was too late to save the leg. The defendants claimed that the patient had lied about prior steroid use and had not returned to the hospital in time to avoid the amputation.

\$10 million medical malpractice verdict reversed

A Washington, D.C., superior court set aside a \$10 million verdict awarded in 1997 to a physician who claimed that staff at a medical center did not diagnose her breast cancer until it was too advanced to cure, according to the April 20 issue of the National Law Journal.

In Wichelman vs. Georgetown University Medical Center, the judge ordered a new trial, which is set for this fall, finding that the trial court had erred in requiring the defense to use its peremptory challenges to remove clearly biased prospective jurors.

The judge also said the plaintiff's conduct of discovery was "characterized by delay, concealment, obfuscation and, at best, grudging compliance with the rules of discovery and fair play."

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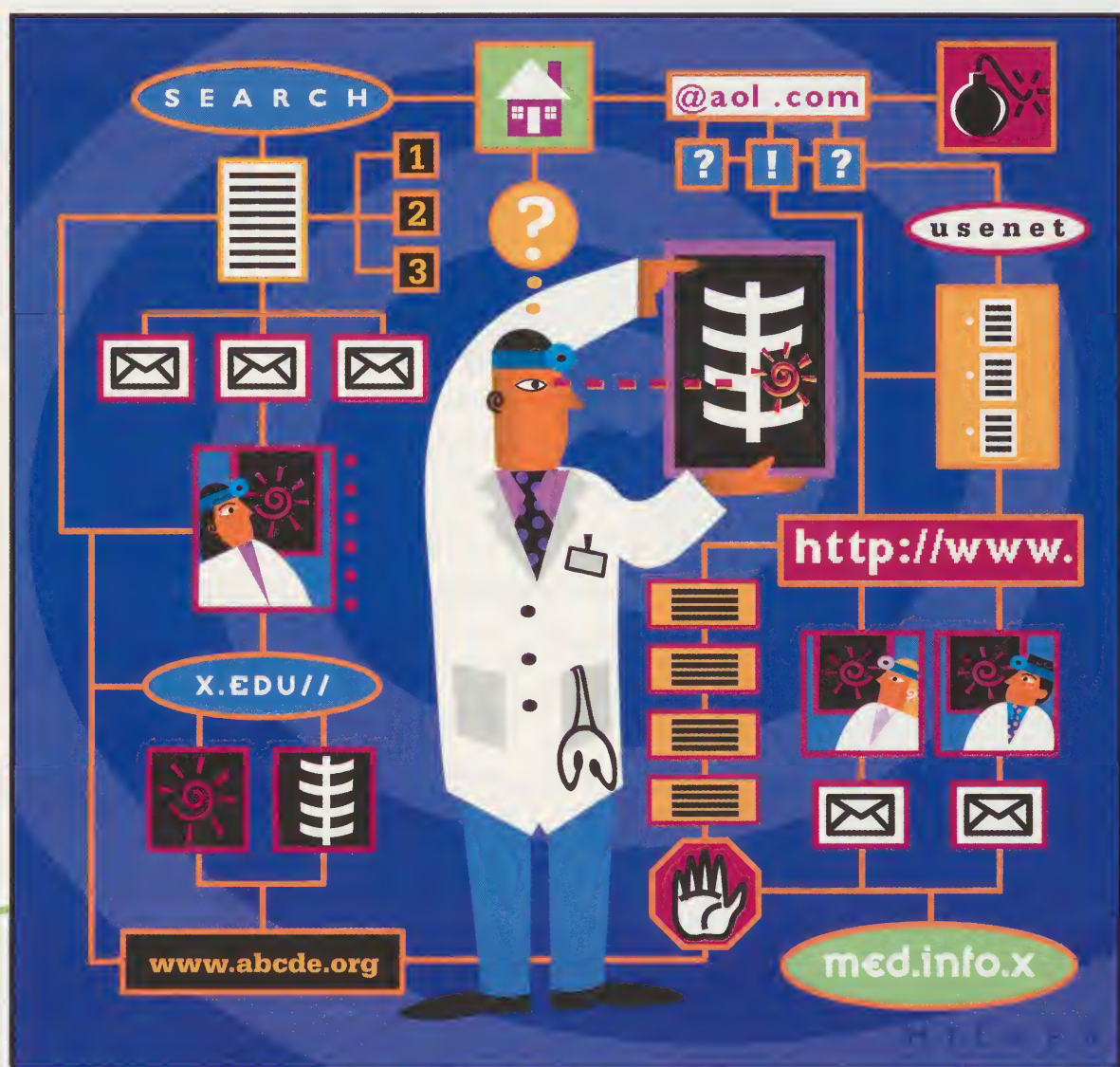
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Net Effect

Physicians explore how to help patients use the Internet. **BY CHRIS PETRAKOS**



Kristen Miller/SIS

Physicians exploring the Internet will likely find most online medical sites falling into one of these two categories: On one side is a growing presence of medical specialty societies, peer-reviewed journals and up-to-date government research; on the other are cranks, quacks and rascals offering cures for every ailment under the sun. One need only look up “women’s health” under a popular search engine, for example, to get a good sense of the range and contradictions of cyberspace. The results from this search will bring up both the National Library of Medicine and a site offering psychic healing.

But, despite hucksters, the Internet is already changing the way physicians and patients approach health care. In 10 years, it’s likely nearly every hospital, doctor’s office and library will offer an Internet link, according to some industry observers.

The NLM has recently decided to revamp the way it delivers information, putting everything on the Internet and abandoning some of its tried-and-true ways of storing records (CD-ROMs, floppy disks and magnetic tapes). The change will take place this year, when the NLM starts placing its popular DocLine interlibrary loan system on the Internet and de-emphasizing its 800 dial-up number.

Web sites recommended by physicians cited in this article:

Illinois State Medical Society:

<http://www.isms.org>

An introduction to the Medical Society that features reports and press releases about ISMS news.

Lake County Medical Society:

<http://members.aol.com/lakeweb>

A prime site for seeing how one local medical society uses the Internet.

AMA:

<http://www.ama-assn.org>

A good starting point for many online searches, this site also offers periodic updates on national health care news.

Quackwatch:

<http://www.quackwatch.com>

A site devoted to countering false health claims.

Evidence-Based Medicine Tool Kit:

<http://www.med.ualberta.ca/ebm/>

A source for physicians offering critical thinking on health topics.

Healthfinder:

<http://www.healthfinder.gov>

A place for patients to begin searching for information on diseases and other medical conditions.

For physicians, the Internet's potential is already offering challenges. An increasing number of patients are showing up for consultations with pages of Internet research. Israel Wiznitzer, MD, principal investigator for Eastern Cooperative Oncology Group at Highland Park Hospital, observed that both patients and their families are bringing him research, much of it quite good.

"Recently, I had a long talk with a patient and her family about aplastic anemia. They had done some searching [on the Internet] and come up with a tremendous amount of information – 35 pages or so – all of it true, all of it current," Dr. Wiznitzer said. "They didn't understand most of it, but I was amazed at what they'd accessed."

Dr. Wiznitzer said it's daunting to realize patients are not only researching the illnesses, but, in some cases, getting second opinions through doctors they find on the Internet. "I had a patient who got a second opinion from a physician. I didn't know who he was, so I went on the AMA Web site where they have a physician profile and I found out that he was a gastroenterologist with no training in oncology. So, to be honest, I didn't think his opinion was valid. I then talked this over with the patient and told her that if she wanted a second opinion she might consider going somewhere like the Mayo Clinic."

Like Dr. Wiznitzer, other physicians say a major problem they face is finding time to look through the research patients bring in. John Renner, MD, an advisory board member for Medicine on the Net magazine and an Internet content manager for Cerner Corp., a health information company, pointed out that how a physician deals with patients who use the Internet depends on their prior relationship. A new patient sitting in the waiting room with 35 pages to read on their first office visit is different, he said, from someone who has been a patient for 10 years and has brought in pertinent material about an illness.

"In either case, you certainly need to listen very carefully and do your best to help the patient separate the wheat from the chaff," said Dr. Renner. "I believe that referring them back to more appropriate material on the Internet is usually the best way to handle these things."

Helping patients interpret what they find is one of the primary problems physicians face, given the sheer volume of information available on the Internet. Some physicians, like Dr. Renner, recommend sites for their

patients to do research. Other physicians, such as those who don't have the time to assess the reliability of the Internet sites, remain open to what patients bring in but decline to direct them in their search. Scott Pierce, MD, professor of Ob/Gyn at Rush-Presbyterian-St. Luke's Medical Center, acknowledged that while he is seeing more patients come in with material from the Internet, he doesn't recommend sites to patients. He does, however, go online himself and locate peer-reviewed articles for patients needing more information. "Some of what is out there is out-of-date or hard to interpret. And some of it is just plain stupid," Dr. Pierce said. In some cases, physicians have to explain that what patients find on the Internet just isn't true, he added.

Dr. Pierce and other physicians are using e-mail more and more to communicate with colleagues and patients. Pierce has consulted via e-mail with a former patient now living in the Czech Republic and even made suggestions to the patient's Czech physician. He also answers questions posed by former patients who have moved around the country. "There are restrictions on the type of information I'm willing to e-mail," Dr. Pierce admitted. "I don't have a problem with sending benign lab results to a patient if they request that, but there are other things just better said in person."

For physicians interested in becoming more Internet savvy, there are a number of options. Computer courses can be found at almost any high school or college. Another place to start may be the local medical society. Four years ago, the Lake County Medical Society started a highly successful program to teach physicians how to use computers and explore the Internet. The county medical society originally set aside enough money from their budget to hire a teacher for small groups of physicians, but it was determined that the best way to teach is one-on-one. Right now, any member can call the society and set up an appointment for at least an hour of guidance through such reliable sites as the popular American Medical Association site.

Physicians alarmed at the bad information available on the Internet need to remember patients have always been exposed to junk science, either from newspapers, magazines or books. Patients who actively participate in their own care need to be welcomed and encouraged, Dr. Renner said. "My advice to doctors is to meet this with humor, with intellect, and as a challenge to do it properly." ■

This information, published as space permits, is reprinted from the Illinois Department of Professional Regulation's monthly disciplinary report. IDPR is solely responsible for its content.

January 1998

Forrest J. King, Alpharetta, Ga. – physician and surgeon license reprimanded for failing to notify the Department of a malpractice settlement in a case in Rock Island County.

Doreena McBride, Bourbonnais – physician and surgeon license placed on probation for one year and fined \$5,000 for securing medical records of patients of Affiliated Pediatrics when she left the practice without approval of patients, and, when requested, failing to transfer medical records in a timely manner.

Michael Miller, Robinson – physician and surgeon license placed on indefinite probation for demonstrating a pattern of incompetency.

Rajan Raj, Des Plaines – physician and surgeon license reprimanded for failing to diagnose and treat a patient's cervical spine instability, resulting in injury to the patient.

Chin Yung See, Waukegan – physician and surgeon license reprimanded for having an unlicensed employee perform physical therapy on a patient.

Timothy R. Scott, Urbana – physician

and surgeon license suspended for one year followed by indefinite probation and controlled substance license indefinitely suspended for nontherapeutic prescribing of methadone.

February 1998

Richard A. Herbert, Oak Brook – physician and surgeon and controlled substance licenses placed on probation for one year for prescribing Dilaudid to four patients under questionable circumstances.

Jacqueline Jordan, Geneva – physician and surgeon and controlled substance licenses placed on indefinite probation for engaging in nontherapeutic self-prescribing.

Mohammed Khaleeluddin, Lake in the Hills – physician and surgeon license summarily suspended for misconduct, including sexual misconduct with female patients.

Romeo LaGrosa, Calrinda, Iowa – physician and surgeon license suspended for 30 days for billing services he did not provide.

Giles Mizock, Chicago – physician and surgeon license reprimanded for failure to diagnose a twin gestation.

Americo Ramos, Lake Barrington – physician and surgeon license suspended for 30 days followed by probation for

two years for submitting bills for two patients for services he did not render or supervise.

Duttala Obula Reddy, Springfield – physician and surgeon license suspended for six months followed by indefinite probation for inducing a patient into sexual relations and failing to treat the patient according to accepted medical standards of practice.

James H. Seubold, Aurora – controlled substance license restored on probation for two years.

March 1998

Chaovane Aroonsakul, Naperville – physician and surgeon license placed on probation for two years if and when her license, which is presently suspended, is restored, and fined \$2,500 for committing acts of fraud in documents connected with her practice of medicine.

Baron Von Baucom, Carbondale – physician and surgeon license restored to indefinite probation.

P. Kevin Barkal, also known as Paul Kevin Barkal, also known as Kevin Barkal, San Diego, Calif. – physician and surgeon license placed on indefinite probation after being disciplined in the state of California.

Julius Bonello, Peoria – physician and surgeon license reprimanded for acting

in an unprofessional manner regarding a patient.

Walter Brodech, Chicago – physician and surgeon license reprimanded and fined \$1,000 for failing to provide, on multiple occasions, the Department's investigators and Deputy Medical Coordinator with a legally requested written explanation concerning a lawsuit involving his medical corporation.

Ignacio Vidal Cabezudo, Rockford – physician and surgeon license reprimanded for submitting bills for treatments to a patient that were not provided.

Richard Famularo, Lake Bluff – controlled substance license issued on indefinite probation after being disciplined in the state of Massachusetts.

Charles Feinstein, Northbrook – physician and surgeon license reprimanded and fined \$2,500 for overcharging a patient for services rendered.

Anil Gupta, Mount Vernon – physician and surgeon license summarily suspended pending proceedings before the Medical Disciplinary Board due to potential mental impairment and/or chemical dependency.

Gregory Huss, Springfield – physician and surgeon license revoked due to drug dependency, diverting controlled substances from patients, and outstanding tax liability owed the Illinois Department of Revenue.

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Hastert describes what he wants to see in federal health care reform

[OAK BROOK]

A key GOP congressman in the national battle for patient rights and health insurance reform gave Illinois physicians a glimpse of what he believes should be included in any proposed federal legislation.

"We want to make sure there's an anti-gag rule in this legislation so doctors can give their advice to the patient, because that's the key to good health care," said U.S. Rep. Dennis Hastert (R-Ill.), who spoke to physicians at the ISMS Public Affairs Breakfast April 25. "We also want to make sure that there's an appeal process so if a patient or doctor doesn't like what happens they could appeal it and get an answer really quick."

Hastert is chairman of the Working Group on Health Care Quality, which is responsible for reviewing bills on health reforms and patient rights. He's been the Republican point man on health care reform since 1992 and served as the GOP representative on first lady Hillary Rodham Clinton's Health Care Task Force. As chief deputy majority whip, Hastert is also responsible for advancing the Republican agenda in the House.

Although the process to craft a reform bill has taken some time, Hastert predicted that legislation may be ready

John McNulty



Hastert said patients need access to good information about their health care plans.

for action this summer. Among the other reforms he would like to see incorporated into a bill are provisions that ensure quality assurance so that insureds and employers can rate the caliber of health plans before they enroll, "When people get an insurance policy, they should know what they're getting."

Hastert said that some efforts have been made to include medical malpractice liability reforms in a managed care bill. M. LeRoy Sprang, MD, immediate past chairman of the ISMS Board of Trustees, explained that physicians want federal tort reform, but ISMS and the American Medical Association are concerned that the passage of liability and managed care reforms would be jeopardized if both are included in a single bill.

Dr. Sprang also said Congress should close a federal loophole created by the Employee Retirement Income Security Act, which exempts self-insured companies from tougher state regulations. "Because insurance com-

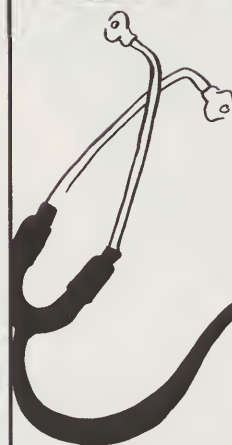
panies are hiding behind ERISA they're not accountable for their actions," Dr. Sprang said. "If they had some risk, they'd respond more quickly."

"Your point is well-taken," Hastert responded. "The whole issue of an HMO or PPO, and not physicians, making medical decisions - there's a problem there." He noted, however, that ERISA was originally enacted to protect companies from numerous state man-

dates that increased the cost of health insurance.

Hastert is also a strong supporter of medical savings accounts, which became available thanks to the Kassebaum-Kennedy legislation. Hastert said he would like to remove the 750,000 limit on the number of MSAs available to the public and to loosen regulations that hinder businesses' ability to sell them.

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Northwestern to build new research facility

[CHICAGO] A collaborative effort between Northwestern University and Northwestern Memorial Hospital will bring a new, \$180 million research facility to the university's Chicago campus, officials announced in April. The project will be funded in part with a \$30 million investment from the hospital.

"This facility will enable us to attract and retain faculty members who will do some of the leading medical research in the country," said Harvey Colten, MD, vice president for medicine and dean of Northwestern University's medical school.

The new facility will have more than 200,000 square feet of research space, and will house about 170 new researchers and more than 1,000 support staff. Space will be provided for research in many areas, including genetics, biomedical engineering, neurosciences and aging.

Construction on the building's first phase will begin next year. The building will be located at Superior Street and Fairbanks Court in Chicago and will join at least five other research facilities on Northwestern's Chicago campus.

"We believe outstanding research enhances the care Northwestern Memorial Hospital provides its patients [through] its efforts to bring research discoveries to patients as soon as possible," said hospital president Gary Mecklenburg.

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Delegates

(Continued from page 1)

his local organization.

At the meeting, physicians cited numerous reasons for seeking to undo the mandatory membership link, including freedom of choice, strength in unity and the failure of the AMA to protect them on issues such as managed care and burdensome government regulations. Most notable of their objections was last year's ill-fated marketing alliance with Sunbeam Corp. that sparked a furor from physicians nationwide when the AMA agreed to place its seal on a line of home

health products in exchange for royalties.

Not all physicians favor deunification. "Divorce would not solve anything, it would only make things worse," said Edward Fesco, MD, chairman of the ISMS delegation to the AMA, in an interview after the House meeting. Although he personally opposes deunification, Dr. Fesco said he sees plenty of room for improvement at the AMA. "First and foremost, there should be an atoning for the problems that came out of the Sunbeam affair," he said, as well as "much-improved accounting" from the association.

Proponents of studying – rather than

enacting – an AMA split said that further research would provide a chance to collect opinions from rank-and-file members across the state. "We have talked [at the Annual Meeting] about getting input from further out, from the backwaters of Cook County and the hinterlands of the state," said Cook County Delegate Lawrence Hirsch, MD, who initially proposed the compromise and later introduced an amendment dictating that the committee makeup not be limited to delegates.

Despite the Jersey-Calhoun group's adamant support of deunification, Dr. Harmon said he believes his members

are willing to hang on for the study's conclusion. "For the first time, we are actually taking a step, maybe just a baby step, to really look at what's really going on," he said.

In addition to considering deunification, delegates passed a series of resolutions demanding openness and accountability from the AMA on the Sunbeam issue specifically, but also relating to AMA activities in general. "These resolutions are about communication and accountability, and I support those concepts," said DuPage County Delegate Raymond Dieter Jr., MD.

Delegates voted to introduce a resolution at the annual AMA House of Delegates meeting in June insisting that AMA trustees publicly take responsibility for the Sunbeam endorsements. Throughout the Sunbeam controversy, AMA trustees have continually maintained they had no prior knowledge of the marketing agreement, instead fixing blame on a handful of senior AMA staff members, a stance that has rankled many physicians.

In his remarks to the ISMS House April 24, AMA Trustee William Mahood, MD, characterized the Sunbeam problem as a "sincere effort by a senior member of [the AMA] staff to get a lot of megabucks into our coffers so we could do these other things we do so well. But it was misguided and what came out of it was actually good," he said.

Some delegates disagreed with that narrow focus for blame. "If the AMA Board of Trustees didn't know, they should have known," said Cook County Delegate Ann Marie Dunlap, MD. Delegate Robert Kaiser, MD, also representing Cook County, said the trustees "need to step up and say the ball was dropped and we are responsible. The board of trustees is ultimately responsible, whether they knew or not."

Delegates passed a resolution demanding an AMA accounting of costs related to the Sunbeam contract. The accounting should include – but not be limited to – the severance costs of terminated employees, the legal costs of investigating and arguing court cases, and all final settlement costs. The AMA is currently facing a \$20 million breach-of-contract lawsuit filed by Sunbeam.

Delegates made it clear they do not want to see a repeat of the type of endorsement that launched such deep physician dissatisfaction with the national organization. They passed a resolution stating ISMS will oppose any future AMA endorsement of commercially available consumer products.

Another resolution directs ISMS to submit a resolution to the AMA calling for the association to annually report all grants and donations it receives. Although the action does not relate specifically to commercial endorsements, the resolution made it clear the "openness on the part of the AMA" would help restore physician trust in the organization. ISMS will also be calling on the AMA to fully explain any public-private partnerships that exist between the AMA and the U.S. Health Care Financing Administration.

In response to the Society's review of its unification status, the AMA issued a statement from J. Edward Hill, MD, chairman of its Committee on Membership, stating that periodic review of activities and relationships is essential for the health and positive growth of any organization. ■

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Medical Society

(Continued from page 1)

cution for unintentional billing mistakes. The resolution also said that appropriate educational materials should accompany any new Medicare coding requirements.

At the AMA's Annual Meeting in June, Illinois AMA delegates will also deliver a strong message that the AMA must work with HCFA to develop appropriate and rational guidelines. These new guidelines should ensure their voluntary nature, decriminalize failure-to-adhere penalties, eliminate random auditing as an enforcement tool and

reflect quality medical care rather than an audit checklist.

The E&M guidelines were intended to help physicians understand how Medicare carriers evaluate patient records during audits. They provide specific instructions about the documentation that must be in patients' charts to substantiate the CPT code assigned on Medicare claim forms. HCFA's recent delay is at least the second one in the past eight months.

HCFA Administrator Nancy-Ann Min DeParle wrote in a letter to the AMA that during the delay "I am directing carriers to continue to use both the 1995 and 1997 guidelines, whichever is

more advantageous to the physician, until the revisions have been completed and there has been an adequate period of time for testing and education." The final version of the guidelines, she wrote, will be strengthened by broad physician participation in the process.

Ensuring physician participation is what initially got the AMA involved in developing the 1997 documentation guidelines, AMA Trustee William Mahood, MD, told the ISMS House during the Annual Meeting. "After three years of effort involving every specialty and representatives to the CPT advisory board, we finally came out with what

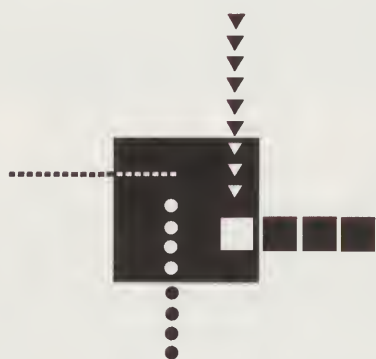
everybody agrees is a monstrosity," Dr. Mahood said.

Now with a second chance to revise the guidelines, the AMA began rewriting them at a meeting of more than 350 physicians and staff from across the country. John Schneider, MD, chairman of ISMS' Third Party Payment Processes Committee, attended the meeting with other ISMS representatives to relay the complaints member physicians have sent the Society over the past few months and the mandates handed down from delegates at the ISMS Annual Meeting in April.

Workgroups tackled proposed changes to the guidelines in the areas of taking patient histories, medical decision-making and elements required for various exam levels. Dr. Schneider conveyed the ISMS delegates' desire for better education about new E&M coding. He made his point with this illustration: A teaching physician should sit with a resident to explain a documentation error and to educate him on how to do it properly in the future – not send a note at the end of the month that says "You don't know what you're doing" without explanation.

ISMS representatives also pointed out that it's necessary to increase advocacy efforts to help various federal agencies understand the hassles these guidelines can create and the need to decriminalize billing-error penalties.

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American Medical Association Organized Medical Staff Section (AMA-OMSS)* Assembly Meeting

June 11-15, 1998
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* The American Medical Association Organized Medical Staff Section (AMA-OMSS) leads and assists grassroots physicians, individually and in groups, to organize and reclaim their role as medical leaders and advocates for excellence in patient care, professionalism, and the integrity of the patient-physician relationship. We provide practical educational forums, focused policy development, and grassroots support through the Federation.

** The AMA designates this education activity for a maximum of 8.5 hours in category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

American Medical Association

Physicians dedicated to the health of America



*"ISMS urges HCFA to
develop appropriate,
rational and voluntary
guidelines for
documenting E&M
services."*

In her letter to the AMA, DeParle addressed these concerns by writing, "Physicians will not be punished for honest mistakes, and we will not make referrals to the Office of the Inspector General for occasional errors." Sanctions would only be placed on physicians who act in "deliberate ignorance" or with "reckless disregard" of the truth, she said. Criminal penalties require "knowing and willful" intent to defraud the government.

The ideas taken from ISMS and others at the recent AMA meeting will now go to the CPT Editorial Panel, which will put the revisions into action, AMA President-elect Nancy Dickey, MD, said. Those results will then be discussed at the AMA's annual meeting in June, and comments will be taken until July. Further revisions will be made based on the input.

The AMA hopes to begin testing the revised guidelines this fall. Dr. Dickey said, "Pilot testing will show us where further changes need to be made. Then, and only then, we will begin the process of education for grass-roots physicians and for carriers."

HCFA plans to evaluate the status of AMA's work in the fall and may set an implementation date at that time. Until then, however, the revision process continues, Dr. Schneider said. ISMS is "obviously going to pay very close attention and monitor it to make sure that, in fact, what is promised, is delivered." ■

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06/02/98



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 battle plans

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Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • MAY 29 1998

Organ donation
 plan pits
 neediest vs.
 nearest

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Citing solid gains, Rockford physicians defer union election

OPTIMISTIC: RPC's united front paves road to reform. BY LINDA MAE CARLSTONE

[ROCKFORD] Satisfied, for now, that its demands for greater control over patient care decisions are being met, the Rockford Physicians' Council has put on hold a request for an

election to become a collective bargaining unit for physicians employed by the Rockford Health System.

"Changes have been made and we want to give the propos-

als a chance to work without the distraction of an election campaign," said RPC President Douglas Kaplan, MD. "We are cautiously optimistic," he said.

They're optimistic enough that the council on May 5 announced it is deferring its petition before the National Labor Relations Board for an election to certify the physicians' group as the negotiating agent of the employed physicians. "We polled the doctors, and the sentiment is that we want to see how the changes play out," Dr. Kaplan said.

The RPC was formed last July by physicians employed by RHS who were increasingly frustrated at being shut out of key decisions that affected delivery of care. "In response to pressure from the council, the [RHS] administration has reinvented its philosophy toward management structure," Dr. Kaplan said. "We are seeing more physician input and involvement, and empowerment

(Continued on page 8)

Nurses' bill gets the green light

As this issue of Illinois Medicine went to press, the Illinois House overwhelmingly passed a bill that appropriately recognizes nurse practitioners, nurse midwives and clinical nurse specialists as part of the health care team. The bill, which the Senate also approved, was sent to Gov. Jim Edgar for his signature.

Negotiators failed to agree on the licensure of nurse anesthetists. A task force will examine the issue and report its conclusions to the General Assembly next spring.

Watch the next issue of Illinois Medicine for a more detailed analysis of the nurses' bill.

Medical Society champions HIV name disclosure plan

GREATER GOOD: Reporting plan aims at early intervention, prevention. BY LINDA MAE CARLSTONE

[CHICAGO] Leslie Soifer absolutely supports the rights of people infected with HIV. She is one of them. Yet, she also believes that "people without HIV have a right not to become infected with the virus."

For that reason, Soifer favors a controversial plan for compulsory name reporting of HIV-infected individuals to the public health authority.

Soifer, a Lake County resident, testified at a public hearing held recently in Chicago by the Illinois Department of Public Health to collect input on the new rule it is proposing. "People are being infected unknowingly and unnecessarily because they believe the love their partners profess goes hand-and-hand

with honesty," she said. "Sadly, this is not always true."

ISMS President Richard Geline, MD, also called on the state to implement a name-linked reporting system. "HIV must be attacked as a public health problem," he said. "Doctors want to stop the spread of this disease and spare our patients from unnecessary suffering and premature death."

"While medicine has developed some remarkably successful treatments, there is still only one cure," Dr. Geline said. "That's prevention. On that count, we still have some work to do."

The rule would require physicians to report names of those who test positive for HIV

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Their support, our gratitude...



Mary Flowers



Suzanne Deuchler



Tim Johnson

Patient rights legislation recently passed in the House, thanks to sponsor Mary Flowers and the four GOP representatives who stood for managed care reform in Illinois.



Gwenn Klingler



Skip Saviano

Patient bills move

MANAGED CARE: Reform down to the wire.

BY LINDA MAE CARLSTONE

[SPRINGFIELD] As the legislative session wound to a close this month, the push for managed care reform held center stage for lawmakers anxious to shift Illinois physicians back into the driver's seat on patient care decisions.

The House and the Senate each passed their own versions of legislation clamping down on managed care abuses blocking patients' access to quality health care. "These bills clearly put patients first," said ISMS President Richard Geline, MD. "We congratulate the General Assembly for taking such a strong stand in favor of patient rights."

In the final week before the legislature's scheduled May 22 adjournment, ISMS feverishly negotiated to ensure that the bill being crafted by Senate Republicans would contain solid gains for patients and physicians. Key victories for the Society were mandates that all enrollees be allowed to choose any primary care physician in the plan, that physicians receive a 60-day termination notice, and that gag clauses, gag practices and retaliation against physicians be banned.

Both the House and Senate bills required passage by the opposite chamber to move legislation on to the governor for approval. The bills' fates were not known when Illinois Medicine reached deadline.

The House bill, sponsored by Rep. Mary Flowers (D-Chicago), passed on a 60-34 vote, with 23 lawmakers voting present. Dr. Geline thanked the four Republicans who voted in favor of the bill: Reps. Suzanne Deuchler (R-Aurora), Tim Johnson (R-Urbana), Gwenn Klingler (R-Springfield) and Skip Saviano (R-River Grove). Their support was critical to getting the bill passed, said Flowers, adding that she was

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Hello stress, goodbye love?

MEDICAL MARRIAGES: High-powered people living high-powered lives need extra doses of attention to cope. BY LINDA MAE CARLSTONE

[OAK BROOK] The words "easy" and "marriage" are rarely uttered in the same sentence. Throw "medical" into the mix, and the likelihood of marital paradise becomes even more challenging.

The medical marriage has a unique set of stresses, according to clinical psychologist Wayne Sotile, PhD, who has clocked more than 60,000 hours counseling couples, including nearly 500 physicians. Sotile has served for 20 years as director of psychological services at the Wake Forest University Cardiac Rehabilitation Program in Winston-Salem, N.C.

"You are high-powered people living high-powered lives," Sotile said in a presentation April 24 at the Illinois State Medical Society Alliance Annual Meeting in Oak Brook. Sotile and his wife, Mary, are co-authors of the book, "The Medical Marriage: A Couple's Survival Guide."

The hazard of high-powered living is coping with the stress of overstacked schedules, a condition Sotile diagnoses as "hurry sickness." The disease is rampant in the medical marriage, said Sotile. He explained that leading the "big life" puts participants at high risk of forgetting what's important in their marriage because they are preoccupied with work.

Attitudes among physicians about work and home life have changed, Sotile stated. A 1979 survey found only 12 percent of male physicians said they were stressed by the work/family balance. By 1989, the number had ballooned to 89 percent.

The new generation of physicians is juggling the stress of home and work, Sotile said. One client told Sotile he constantly feels torn between work and home. His wife wanted him to

devote more time and attention to their home life. "My colleagues asked if I wanted to be a doctor or a home-maker," he told me."

Sotile revealed tips on how medical couples can avoid or escape the risks of life in the fast lane:

- Willingness to renegotiate the contract: The myth is that relationships evolve naturally, he said. The reality is that they take work. Loss of friendship is the No. 1 cause of divorce. Friendship is lost by not evolving in the relationship and not being open to

change in your partner.

- Communication rituals: Moments of connection are necessary to keep a relationship alive, Sotile said. If you are not learning something new about your spouse every two weeks, you are not paying enough attention. Quiz yourself, he challenged. Do you know what your spouse is dreaming of, looking forward to? Do you know his or her deepest secrets?

- Little changes make a profound difference: Small but important ways to convey love include hugs, tender e-mail, an evening stroll together and bringing your mate a glass of water. The time investment will take no more than 10 minutes a day, in 20-second spurts. In the long run, he said, it "can save you \$20,000 of marital therapy."

The good news, Sotile concluded, is that medical families can epitomize a marriage "done right" — when they decide to work at it. Many times, he said, this decision is made "after an affair, or after a first or second marriage. But sooner or later most doctors decide to do it right."

To order a copy of "The Medical Marriage," call (888) 629-2313. ■



Wayne Sotile, PhD

John McNulty



John McNulty

ISMS ALLIANCE past President Julie Ringhofer (left) of Belleville, shares a moment with new Alliance President Marybeth Syfert (right) of Macomb during the officer installation April 24. The Alliance will focus its efforts this year on "Building Healthy Partnerships 2000."

ISMS House selects delegates to the AMA meetings

[OAK BROOK] The 1998 ISMS House of Delegates elected its delegates and alternate delegates to the American Medical Association House of Delegates during the ISMS House meeting in Oak Brook April 26.

Returning as delegates in 1999 will be: James Andersen, MD, of Oak Brook; Dennis Brown, MD, of Schaumburg; Clair Callan, MD, of Lake Forest; Chester Danehower Jr., MD, of Peoria; Edward Fesco, MD, of LaSalle; Earl Fredrick Jr., MD, of Chicago; and John Schneider, MD, of Chicago.

Formerly serving as alternate delegates, the following assume delegate positions in 1999: Richard Geline, MD, of Skokie; Ronald Ruecker, MD, of

Decatur; and Janis Orłowski, MD, of Chicago. Rebecca Bezman, MD, a resident physician in Chicago, will also assume a delegate position in 1999.

Returning as alternate delegates to the AMA in 1999 will be: William Kobler, MD, of Rockford; Nestor Ramirez, MD, of Urbana; and Norman Scheibling, MD, of Springfield.

New alternate delegates are: Shastri Swaminathan, MD, of Chicago; Jerome Frankel, MD, of Evanston; Raj Lal, MD, of Lombard; Terry Ostrowski, of Park Ridge; and Jane Jackman, MD, of Springfield. Mary Abusief, a medical student from Springfield, also assumes an alternate delegate position in 1999. ■

Appellate court reverses decision in Holden case

[ELGIN] Earlier this spring, the Second District Appellate Court reversed a previous decision in Holden vs. Rockford Memorial Hospital and struck down the ban on the corporate practice of medicine. Justices cited the Illinois Supreme Court's fall 1997 decision to lift the ban on licensed hospitals as a reason for their change of heart.

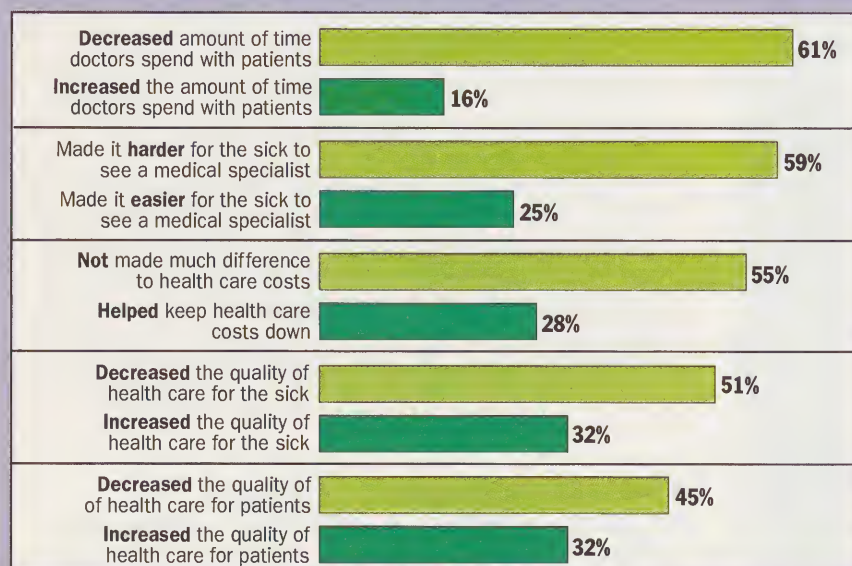
More than a year ago, the appellate court issued its original ruling in favor of John Holden, MD, who had asked the court to nullify an employment contract he signed with Rockford Memorial Hospital because the state prohibited hospitals from practicing medicine. The hospital appealed the decision to the state's high court.

However, a similar case — Berlin vs. Sarah Bush Lincoln Health Center — had already reached the Supreme Court. In October, the Supreme Court ruled in Berlin that the state ban on the corporate practice of medicine does not apply to licensed hospitals. This spring, the Supreme Court declined to reopen the issue with the Holden case, but directed the appellate court to reconsider its decision in light of the Berlin decision.

"The issue in [the Holden] case was squarely before the Berlin court," according to the appellate court's decision. "Like the physician in Berlin, Dr. Holden had an employment agreement with a hospital and sought to leave his employment after having his contract declared unenforceable. As the Berlin court held, however, the corporate practice of medicine doctrine does not apply to hospitals." The appellate court concluded that Dr. Holden's employment agreement could be enforced. ■

Public has Negative Opinions About Managed Care

Percent of Americans who say during the past few years
HMOs and other managed care plans have...



NOTE: "No effect" and "Don't know" not shown.

SOURCE: Kaiser/Harvard National Survey of American's Views on Managed Care, 1997.

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Organ donation plan pits neediest vs. nearest

CONTROVERSY: Physicians fear the idea would allow the government to dictate medical policy.

BY ELIZABETH AGNVALL

[CHICAGO] Nearly 300 Illinoisans died while waiting for organ transplants in 1997. So, when the Clinton Administration recently ordered changes in the way the life-saving organ donations are distributed, it plunged into the middle of a complex and thorny controversy that soon had some Illinois physicians crying foul.

The plan is to distribute donor organs to the sickest of the 54,000 Americans waiting for livers, hearts, lungs, pancreases and kidneys, regardless of geography. U.S. Health and Human Services Secretary Donna Shalala ordered the United Network for Organ Sharing, the national umbrella organization that oversees organ allocation, to devise a new plan. She gave them less than six months to devise the new system for liver allocation and a year for other organs. The network must also come up with standard medical criteria for placing patients on waiting lists and standard criteria for determining the medical status of patients on the list.

Under the current distribution system, when an organ becomes available, the United Network for Organ Sharing's computer searches first locally, then regionally and nationally for a patient in need. As a result, waiting times vary from region to region. The new guidelines charge the organ-sharing network to develop organ allocation policies giving priority to those whose needs are most urgent, regardless of where they live, leading to more equal waiting times for patients with the same medical status.

For many Illinois surgeons, the new regulations smack of government dictating medical policy.

"It's a dangerous precedent to set," said Richard Thistlethwaite, MD, chief of transplant surgery at the University of Chicago Hospitals. "It's only one step away from making the same type of mandates related to cost of care."

While Dr. Thistlethwaite agreed that an ideal system would assure patients equitable access to organs, he questioned the decision to give priority to the sickest patients, especially in regard to livers, which can last outside the donor's body for 12 hours before beginning to deteriorate — long enough to make a cross-country trip by jet. About 4,000 livers are available for 10,000 critically ill patients each year.

Dr. Thistlethwaite said that if doctors transplant only the sickest patients, fewer patients may die on the waiting list, but more will die after the operation. And, because of their instability, the sickest patients often require second and third transplants. "I feel very strongly that we need to look where we'll do the greatest good with this limited resource," he said.

John Brems, MD, director of abdominal transplantation at Loyola University Medical Center in Maywood, fears that taking away geographical boundaries could cause a decrease in local organ donations. "When we go to a national system, it's going to decrease organ donation locally," he said.

The new regulations will reallocate donated livers away from the majority of the country's 120 transplant centers and

shift them to a half-dozen large surgical centers. Preston Foster, MD, a liver transplant surgeon at Rush-Presbyterian-St. Luke's Medical Center, said that people without the financial means to travel to the larger centers could be forced out of the system. He also said it's naive to ask physicians all over the country to standardize the way they think about patients. "Maybe what

we're really interested in is having all doctors think the same way," Dr. Foster said.

All parties involved in the debate do agree on one thing: an ideal solution is to increase the number of organ donors. Secretary of State George Ryan's office spent \$2 million in 1993 raising donor awareness, and Ryan's spokesperson, Dave Urbanek said the

key to the problem is for all states to increase supply. Since 1992 the secretary of state's office has asked driver's license applicants if they are willing to donate organs. With 4 million registered donors, Illinois has the largest donor registry of any state.

"With any national program, we should not only talk about who gets the organs, but also, more importantly, how we expand the system," Urbanek said. "Here in Illinois, we have done a terrific job with the organ donation awareness program, but the need continues to grow. That's where the real problem is." ■



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REPORT for Illinois Physicians

ILLINOIS MEDICARE

SKILLED NURSING CARE UNDER MEDICARE HOME HEALTH BENEFIT

To receive reimbursement for home health care, a beneficiary must be under the care of a physician who has certified that medical care in the home is necessary and who has established a plan of care for the beneficiary. The beneficiary also must be confined to the home and must need intermittent skilled nursing services, physical therapy or speech language pathology services, or have a continuing need for occupational therapy. The venipuncture provision in the Balanced Budget Act of 1997 (BBA), Section 4615, removes blood draws from the list of skilled nursing services that qualify a beneficiary for home health care. Venipuncture is the withdrawing of venous blood, typically used for analysis of the blood sample. If the beneficiary needs only blood drawn, he or she will not qualify for the home health benefit. However, if an individual requires skilled therapy or nursing services, he or she can continue to receive home health services, including venipuncture.

Medicare still pays for blood draws under Part B. Under Section 1861(s)(3) of the Social Security Act (the Act), beneficiaries who only need their blood tested on a regular basis can continue to have their blood monitored. In addition, if a physician determines that a beneficiary is unable to travel to a laboratory or the physician's office for the blood draw, Medicare Part B will pay for the specimen collection and travel by a technician to the beneficiary's residence under Section 1833(h)(3) of the Act.

It is reasonable to expect that some beneficiaries receiving home health, where venipuncture was the previous qualifying service, have medical situations that appear medically complex enough to qualify for other skilled nursing services. Section 205.1 of the Home Health Manual lists numerous specific services which, if reasonable and necessary, can be considered qualifying skilled nursing services. Observation and assessment of a patient's condition and management and evaluation of a patient's care plan are included in this list and are particularly relevant in light of the venipuncture provision. These services can be considered reasonable and necessary skilled nursing services in certain circumstances, as discussed in the manual.

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EDITORIAL

Finding new solutions

When the U.S. Health Care Financing Administration recently announced that implementation of the entirely unworkable E&M guidelines for use with Medicare claims would be delayed yet again, some physicians had an unsettling sense of déjà vu. During this delay, HCFA vowed, there would be time to develop and test the newest version of E&M guidelines to make sure they could actually be used in practice. Hasn't this been promised before?

But maybe this time something will be done to alleviate the problems that physicians saw with the guidelines in the first place. After all, this newest – and for now, indefinite – delay came after organized medicine spent months putting more pressure on HCFA to produce better, feasible guidelines that could be used in day-to-day medical practice.

For months, physicians had been troubled by a bureaucratic nightmare they saw in these proposed guidelines. One by one, physicians found their pulses racing as they discovered that the guidelines originally proposed to help them record more accurate E&M codes would only add to the insurmountable paperwork their offices now faced. Visions of hiring additional staff members solely to process this data danced in their heads, as did the threat of persecution by overzealous federal officials who didn't care about the difference between an innocent billing mistake and a malicious

act of fraud. Physicians' time is better spent on appropriate patient care, not circuitous record keeping.

These problems caught the attention of organized medicine, and the AMA and ISMS responded accordingly. The AMA, for example, scheduled a special meeting in April to fly experts from across the nation to Chicago to discuss what needs to be done to help HCFA develop guidelines that work.

In a few weeks, Illinois' delegation to the AMA's Annual Meeting will be armed with a resolution asking our national organization to continue working with HCFA to create guidelines that serve a legitimate purpose without creating an administrative headache. The resolution asks the AMA to help assure that compliance with E&M guidelines is voluntary, that failure-to-adhere penalties are decriminalized and that random auditing is eliminated as a way to get physicians to comply. In other words, the E&M guidelines should reflect and enhance quality medical care, not simply add another layer of bureaucracy and paperwork to the physician-patient relationship.

When physicians saw the errors of the proposed E&M guidelines, they responded appropriately by seeking assistance from organized medicine. Thanks to the pressure that ISMS, the AMA and all of organized medicine have put on HCFA, physicians just might get guidelines they can put into practice.

PRESIDENT'S LETTER

E&M guidelines demand continued physician attention

Richard A. Geline, MD



This is not, however, a time to relax, and we must stay alert so we can stay alive.

Perhaps the most pressing issue confronting physicians this spring has been the proposed – and subsequently delayed – E&M documentation guidelines developed for the U.S. Health Care Financing Administration.

The issue has been so much in the forefront of physicians' minds that seven resolutions related to the topic were submitted at the recent ISMS House of Delegates Annual Meeting, along with two resolutions on the closely allied matter of fraud and abuse. Developing clear, precise and viable E&M documentation guidelines has been a priority for physicians involved in organized medicine and will remain so until physicians have something that works.

This issue originated in 1989 as a spinoff of the resource-based relative value scale program in an attempt to standardize the meaning of each CPT designation. In 1992, HCFA developed and adopted a revised set of E&M codes for Medicare claims. Throughout 1993 and 1994, the codes were further refined and defined.

However, physicians found a number of weaknesses, particularly from the viewpoint of specialists. As a result, physicians and others devoted further effort to achieve uniformity so that certain CPT codes would have the same meaning under all circumstances. This led to a further update published in a June 1997 Federal Register, with the changes scheduled to go into effect Jan. 1, 1998.

A parallel development was passage of the federal Health Insurance Portability and Accountability Act of 1996, better known as the Kassebaum-Kennedy bill. This law established a special account within the Medicare trust fund earmarked toward combating Medicare fraud with increased civil and criminal penalties to be applied against individuals found guilty in these areas. As part of its antifraud initiative, the inspector general began a series of audits of teaching hospitals and private physician practices.

The new documentation guidelines yield incredibly complicated

and detailed requirements incompatible with routine daily practice, let alone the added costs necessary for internal compliance. Opposition and resistance developed as soon as the new guidelines were published, and the AMA House of Delegates at the 1997 Interim Meeting passed a resolution calling for scaled-down application and testing, along with relief from fraud and abuse penalties for inadvertent clerical errors. Almost simultaneously, because of the efforts of organized medicine, HCFA announced a six-month delay in implementation to July 1.

Throughout the spring of 1998, the dialogue continued on many levels both formal and informal, and local, regional and national in scope. The effort culminated in an AMA-sponsored one-day program on April 27. At the meeting, HCFA officials announced plans for:

- An indefinite grace period to allow the guidelines to be tested and to instruct physicians and carrier review personnel about them.
- Instructing Medicare carriers that physicians are not to be punished for honest mistakes.
- Continued work with physicians to develop guidelines easier to understand and more realistically related to the care provided.

The announcement represents a distinct triumph for the efforts of physicians and organized medicine at all levels. Credit is well-deserved by all who participated and contributed to the process. This is not, however, a time to relax, and we must stay alert so we can stay alive. The announcement represents a delay – not a cancellation – of the effort to develop workable guidelines. Physicians must continue to be involved to meet the stated goal of appropriate payment without posing undue burden on physicians. To be certain, the ISMS at all levels of staff and physician leadership will be watching closely as developments unfold. Share with me your thoughts on how we can be of further service.

GUEST EDITORIAL

A cure for cancer? A sober look at breakthrough research

By Joan Beck

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It's the pot of gold at the end of the research rainbow. The Holy Grail of medicine. The light at the end of the terrible tunnel of surgery, chemotherapy and radiation. The philosopher's stone of physicians. An answered prayer.

And for a few giddy minutes, it seemed close enough to grasp. Two new drugs that act to inhibit the growth of new blood vessels can cause cancerous tumors to shrink and disappear, said a news report. Cautiously, cancer researchers were quoted using the word oncologists usually dare not speak: "cure."

For millions of those who are fighting cancer or love someone who is, the news offered a reprieve from what often seems like a sentence of death, a blessed escape from debilitating rounds of chemotherapy and radiation and a hope that the future would hold more than a choice between hospice and hemlock. No wonder they are besieging researchers and doctors, beseeching for the new medications, offering their stories of desperation, their willingness to be an experimental subject, even in a case reported in The New York Times, "a large infusion of cash."

Excited investors drove the stock of a small biomedical company involved in the new drugs up by more than 300 percent May 4 in a rare buying frenzy that began even before the stock market opened. The euphoria spilled over into other biotech stocks and renewed interest in other medications under development.

But hold the Nobel Prize for a while. Wait a bit for the honorary doctorates, the victory visits to the White House and the scientific halls of fame. Don't cancel your appointment for chemotherapy or a mammogram. Don't risk cancer with smoking or too much exposure to the summer sun. We aren't home cancer-free yet.

What's causing the unprecedented exuberance is the announcement of studies showing that two drugs, angiostatin and endostatin, can cause cancers to shrink too small to be detected – in mice. Unlike other cancer therapies, the drugs had no unpleasant side effects such as nausea, hair loss, neuropathy and lowered blood counts – in mice. Unlike medications for human patients, the drugs worked on all types of cancer – in mice. And unlike so many cases of cancer in humans, the tumors did not return when both of the drugs were given together – in mice.

The drugs are a dramatic new approach to cancer, based on the theory of Judah Folkman, MD, a cancer researcher at Children's Hospital in Boston, that if cancer cells are prevented from establishing their own blood supply, they cannot grow beyond microscopic size. The new drugs stop the growth of these blood vessels, starving the cancer cells and eliminating them. Because the drugs don't act directly on them, the cancer cells don't develop a resistance, as they often do to chemotherapy medications.

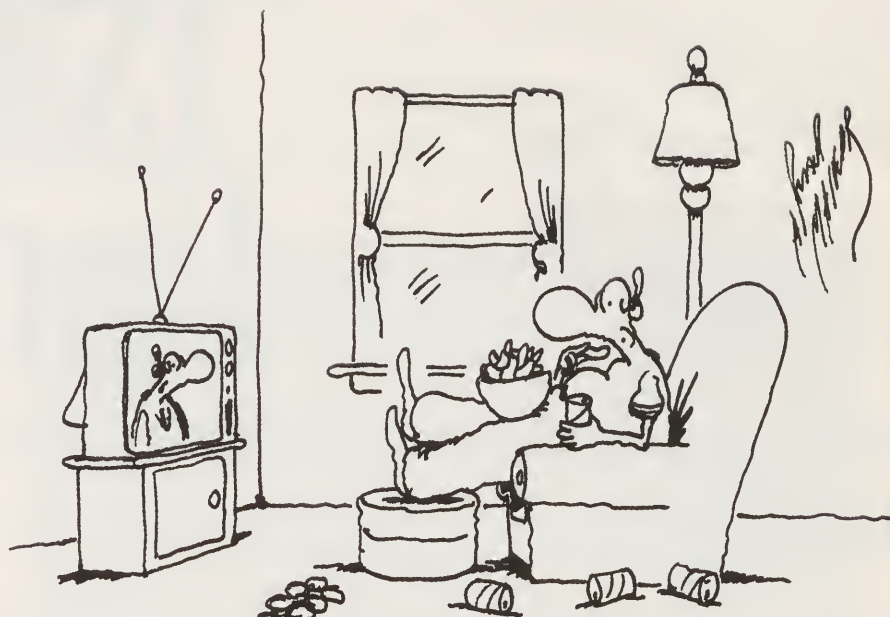
Drugs that work on this principle of anti-angiogenesis are being tested by other researchers. But the studies by Dr. Folkman and his colleagues are the most dramatically successful.

The catch now, of course, is that human beings aren't mice. Many new therapies that seem to work well in mice aren't effective in people. So until angiostatin and endostatin have been subjected to rigorous testing in human trials, the jubilation about their discovery is premature. First, the drugs must be used in clinical trials to make sure they are safe, that they don't cause serious side effects in people that didn't occur in mice. Then, further clinical trials are necessary to show that they are effective, sometimes in comparison with established medications. Finally, the Food and Drug Administration must approve the data before the drugs can go on the market.

Human trials can't even begin until more angiostatin and endostatin can be produced – probably in 12 to 18 months. It may be years before the drugs are generally available for cancer patients, even if the trials are successful and the drugs are proven to be safe and effective.

Demands for the drugs from cancer patients and their families are already intense and will undoubtedly grow if human trials show that the drugs work as well in people as in mice. Cancer takes a terrible toll. It has forced millions of people to submit to the crude and brutal treatments of surgery, radiation and/or chemotherapy. Survivors worry that the disease may return.

Even if the drugs turn out to be successful in human clinical trials, it may



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avoid them. These experts also point out some shadowy contract language and explain why the language could trap physicians into difficult situations.

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be difficult to produce enough quickly to meet the huge demand. Then some painful decisions may have to be made about who will get them first, as now must be done with organ transplants. Should those who are sickest come first? Or the newly diagnosed with the best chance of survival? Children? Young parents with dependents? Those who can afford to pay the highest prices?

But there is time to worry about all that later. For now, let's rejoice that there is new hope for those with cancer – if not for ourselves, at least for those who may have inherited our genetic susceptibility. Let's push Congress and the White

House to make sure there is no shortage of money to hurry these drugs along, that there are plenty of funds for quick and extensive clinical trials, that enough researchers and production facilities are available to speed the work. Let's keep on trying to develop other new kinds of therapies and doing research into the causes of cancer. Let's look hard at the FDA to make sure its bureaucratic procedures don't add unnecessarily to the time it takes to bring urgently needed drugs to those who need them.

And let's, at least for now, be thankful for a rare bit of good news about cancer – if it is only in mice.

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Coming soon:
case-in-point

ISMIE Update

ISMIE rating upgraded again, now a strong B++

Premiums will remain stable for 57 percent of ISMIE policyholders. BY JANE ZENTMYER

As ISMIE takes steps to continue its high-quality service, the national rating agency A.M. Best Co. announced an upgrade of ISMIE's rating to B++ or "very good."

"A.M. Best only assigns this rating to companies it considers 'secure,' and this upgrade should assure policyholders that ISMIE is strong," said Harold Jensen, MD, chairman of the ISMIE Board of Governors. "Illinois physicians can count on ISMIE to be here through good times and bad."

A.M. Best cited ISMIE's strong position in the state's medical malpractice market, improved operating results and adequate loss reserves as reasons for the upgrade. According to A.M. Best, "ISMIE is the leading provider of professional liability insurance for physicians in Illinois." A broadened marketing focus will likely strengthen ISMIE's lead position by attracting physicians practicing primarily in Illinois, but in neighboring states as well.

Before 1995, ISMIE was assigned a nonrating of NA-6 by A.M. Best, since the company didn't have a rating procedure to apply to ISMIE's European reinsurers. Such a procedure was subsequently developed, and in 1995 ISMIE received its first A.M. Best rating, a B. The following year the B was upgraded to a B+.

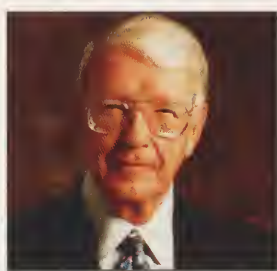
ISMIE's drive toward even

better ratings recognizes the reality of the competitive liability insurer marketplace that currently exists in Illinois. "Many of the decisions to buy malpractice insurance for groups are made by business managers who are often nonphysicians," Dr. Jensen said. "Often they will only consider companies they know to be solid."

As ISMIE works to increase its competitiveness, its commitment to policyholders remains firm, Dr. Jensen said. In 1997, trial activity reached an all-time high, and ISMIE had a 78 percent victory ratio among cases that went to trial. Satisfaction surveys regularly ask physicians to rate ISMIE's claims service on a scale of 1 to 10, with 10 as the highest score. ISMIE's average score is a 9.

"That's what separates us from other carriers – our willingness to take cases to trial and our unparalleled level of service to physicians, particularly those going through the trying times of litigation," Dr. Jensen said. "You don't get that kind of service from anyone else."

TO MAINTAIN HIGH QUALITY service for physicians, as well as its viability in a competitive market, ISMIE recently reevaluated its rates and decided to increase them for some policyholders effective July 1. Specifically, the base rate will rise for those policyholders who have had a recent



*"Illinois physicians
can count on
ISMIE to be here
through good times
and bad."*

— Harold Jensen, MD

paid claim. But sliding-scale discounts given to physicians based on their loss histories could offset part or all of any rate increase.

At least 57 percent of ISMIE's policyholders haven't had a loss in eight years, and those physicians will see no increase in their premiums. "We believe that these 57 percent of physicians have helped themselves and their fellow ISMIE policyholders through their good loss experience," Dr. Jensen explained. "As such, they should and are being rewarded by not having to pay any increase."

Fewer losses in oncology, ophthalmic surgery, plastic surgery and orthopaedics without spinal surgery will result in rate decreases for physicians in these specialties. However, the decrease may or may not be offset by the rate increase, depending on the policyholder's claims history.

ISMIE is forced to raise rates for some physicians because of several factors, including the "runaway" legal system in Illinois, Dr. Jensen explained. Large sums have traditionally been awarded to plaintiffs with catastrophic injuries. But, Dr. Jensen said "juries are returning verdicts that demonstrate they no longer feel \$1 million is a large sum."

In 1992, ISMIE paid more than \$1 million for three verdicts against the defense. In 1997, however, sums more than

\$1 million were awarded to plaintiffs in 10 cases involving ISMIE-insureds. "And this trend is continuing," Dr. Jensen noted. "Already in 1998 a plaintiff has been awarded \$1.1 million for a cornate ectopic pregnancy that resulted in the loss of one fallopian tube. To us that seems unbelievable, but it's true."

The rate increase – the first in two years – also reflects an increase in inflation. The inflation rate rose by 5.3 percent since the last increase, and economic experts predict another 2.2 percent rise in 1998. Dr. Jensen said, "This combines for a total inflation rate of 7.5 percent and is a factor in the cost of doing business, including defense attorney expenses and performing the functions that allow ISMIE to maintain the level of quality service its policyholders expect." ■

ISMIE seminar looks at employment and business risks

Today's business climate makes such routine procedures as checking a potential employee's references or dismissing an unproductive worker rife with possible risks of lawsuits.

A four-hour seminar presented by ISMIE, called Managing and Reducing Physician Employment and Business Risks, will address many of the ways physicians can reduce their exposure to employment and business practice claims.

The seminar will help physicians identify possible liability exposures as a result of inappropriate employment and managed care practices. In addition, physicians will learn about the possible risks of patient injury associated with the year 2000 "bug."

ISMS developed the program, which will earn 3.75 hours of Category 1 credit toward the American Medi-

cal Association's Physician's Recognition Award. The seminar has been designed for physicians, practice and managed care administrators, business coordinators and anyone else interested in reducing risk in this area.

The seminar has been scheduled for three dates:

- June 12, Rosemont Holiday Inn O'Hare;
- June 17, Springfield Renaissance Hotel;
- Sept. 17, Collinsville Holiday Inn.

The seminar costs \$50 per person for ISMIE-insured physicians and their employees; \$100 per person for all others. Registrations and payment must be mailed to the ISMIE Risk Management Division, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602. For more information or a brochure, call the Risk Management Division at (312) 782-2749 or (800) 782-4767.

MALPRACTICE ROUNDUP

\$12M awarded in bile duct case

A New York man's attorney said that while the perforation to his client's bile duct was not negligence, it was a foreseeable risk of the endoscopic procedure to remove gallstones, according to the April issue of Medical Malpractice Law & Strategy. In Lieberman vs. Maimonides Medical Center, a jury awarded the patient \$12 million after he was left without most of his stomach, intestines and pancreas.

The patient claimed that the endoscopist neglected to diagnose the perforated bile duct and treat it immediately. Because of the delay in diagnosis, an abscess formed in his pancreas, which, in addition to the bile and other digestive juices leaking into his digestive tract, caused self-digestion of several of his organs. This ultimately led to an ileostomy, gall bladder removal and the insertion of a bypass tube.

The endoscopist was found 60 percent liable, with the remaining liability apportioned among several other physicians.

Annual Meeting Recap

AMA deunification and E&M coding weren't the only topics drawing fire at the recent ISMS House of Delegates Annual Meeting. Delegates also devised tactics for campaigns on several fronts, vowing not to give up their struggle until the operation is a success.

Tackling court abuses



Because a runaway court system interferes with physicians' ability to care for patients, delegates identified the following key issues:

Tort reform

ISSUE: Frivolous lawsuits needlessly drag physicians through the legal process, driving up the costs of malpractice insurance.

ACTIONS:

- ISMS will review strategies to restore the caps on malpractice cases approved by the Legislature in 1995 and overturned by the Illinois Supreme Court last November.
- ISMS will support tort reform strategies that include efforts to elect judges who more closely appreciate the intent of the Legislature.

Decriminalizing medical mistakes

ISSUE: Overzealous prosecutors continue to bring criminal charges against physicians for medical mistakes.

ACTIONS:

- ISMS will oppose the criminalization of medical mistakes.
- ISMS will support the cause of New York surgeon Gerald Einaugler, MD, convicted on manslaughter charges, by writing a letter to New York Gov. George Pataki and encouraging all ISMS members to do the same.

Breaking government's grip



Fed up with multiple layers of government regulation and facing the constant fear of government reprisal for inadvertent billing errors, delegates mapped out ISMS strategy on the following issues:

Medicare

ISSUE: Restrictions on physicians and patients are among the many governmental obstacles complicating Medicare and often reducing the availability of quality care.

ACTIONS:

- ISMS will support the right of Medicare patients to contract independently for medical services they are willing to pay for themselves.
- ISMS will back legislation voiding any law requiring physicians who independently contract with Medicare patients to be exiled from the program for two years.
- ISMS will oppose the imposition of any fee for physician participation in Medicare.

Fraud and abuse

ISSUE: Physicians are increasingly anxious that their innocent billing mistakes may make them targets of federal fraud and abuse investigations.

ACTIONS:

- ISMS will urge the AMA to:
 - Review current fraud and abuse laws, and propose any necessary changes.
 - Ready itself for legal action assuring physicians due process during investigations.
 - Pursue legislation decriminalizing billing errors and reducing excessive fines for mistakes.
 - Ask the necessary federal agencies to establish an auditing policy

(Continued on page 8)

Battle Plans

The continuing challenge of physician control of patient care decisions in a growing managed care environment will stay on ISMS' front burner, and include the following issues:

Confronting managed care



Protecting patients

ISSUE: Patient awareness is key, whether by educating patients to managed care contract abuses or helping them realize the importance of establishing a relationship with a physician at the time of enrollment.

ACTIONS:

- ISMS will launch a high-profile public education campaign to call attention to managed care abuses – including gag clauses, confidentiality issues, interference with medical decision-making and access to emergency care – that jeopardize quality patient care.
- ISMS will work for a law requiring managed care companies to inform new patients about the availability of care and how to use it, and to provide them with a list of available physicians.

Paperwork overload

ISSUE: As managed care companies multiply, so do requests for documents such as licenses and proof of malpractice coverage that accompany managed care accreditation applications.

ACTIONS:

- ISMS will explore the possibility of bringing to Illinois the American Medical Accreditation Program – a voluntary, centralized, credentialing system – to reduce the cost, hassle and duplication of paperwork and office inspections now requested.
- ISMS will monitor test sites where the AMA and other state societies are jointly participating in AMAP.

Reacting to wide-ranging threats to patients and the public health, delegates committed the Society to these actions:

HEPATITIS B VACCINES

- ISMS will continue to support the state's requirement to vaccinate schoolchildren against Hepatitis B and to expand public education on the disease.

CLEAN NEEDLES

- ISMS will support improved access to sterile needles in an effort to slow the spread of blood-borne pathogens such as Hepatitis B and HIV.

PVC PLASTIC

- ISMS will support a move at the next AMA annual meeting to eliminate polyvinyl chloride plastic medical products as a way to reduce dioxin contamination.

DOMESTIC VIOLENCE

- ISMS will support the use of hospital-based on-call social workers in hospital emergency rooms to help with domestic violence situations.

- ISMS will continue its medical education efforts to build awareness of the signs and symptoms of domestic violence.

BETTER HOSPITAL DECISION-MAKING

- ISMS will ask for medical staff-developed CE and orientation programs for members of hospital governing boards – as part of their accrediting and licensing process – in an effort to provide stronger

(Continued on page 8)

Fortifying public health



Breaking

(Continued from page 7)

that doesn't interfere with routine patient care.

Coding

ISSUE: Clear, precise and viable coding continues to be a top priority for organized medicine.

ACTIONS:

- ISMS will direct the AMA to:
 - Review the CPT manual, simplifying and reducing the number of available codes.
 - Develop appropriate informational and educational materials.
 - Make CPT information available in a less costly fashion.

Fortifying

(Continued from page 7)

backgrounds for decisions affecting patient care.

ACCESS TO CARE

- ISMS will continue to condemn actions by hospital administrators or governing boards, like the recent turmoil at Kewanee Hospital, that reduce or withdraw physicians' hospital privileges because of issues not related to professional competence, conduct or ethics.

HUMAN CLONING

- ISMS will study a proposed moratorium on efforts to clone entire human beings. ■

Citing

(Continued from page 1)

of those physicians who were in charge but didn't have responsibility," he said.

"We are pleased with the progress and believe it shows what a united physician front can accomplish," said ISMS President Richard Geline, MD. The council's campaign to organize was formally endorsed last October by the ISMS Board of Trustees, which commended the council's efforts "to achieve a strong, independent voice for the physicians it represents, toward furthering the goal of high quality patient care."

The Society has continually provided administrative aid to the council as it prepared and distributed a statement of principles and position papers about how to improve physician influence at RHS. Dr. Geline said the Society will continue to monitor the situation to make sure the movement proceeds in the direction of patient-centered, physician-driven health care.

The backing of the Society and the AMA provided a strong air of credibility to the movement, Dr. Kaplan said. "It showed we were mainstream medicine – that we were a group of physicians interested in patient care and not a traditional labor union."

Council organizers said that gains secured since the group came into existence include: increased physician representation on the RHS board; creation of a chief operating officer

position to be held by a physician; the physicians' right to validate the selection of department heads; development of an advisory system council and operations council that include physicians; and the replacement of several department and section chairmen.

The election had been delayed while the NLRB looked into an unfair labor practice complaint from the council that the RHS interfered with its efforts to organize. In a preliminary step, the NLRB sided in favor of the physicians and was in the process of conducting hearings on the matter. The election was also held up pending an NLRB ruling on which physicians were eligible to vote.

The election-withdrawal decision does not mean the council is disbanding. "We will continue to meet every couple weeks and keep our fingers on the pulse," Dr. Kaplan said. "We're concerned whether these changes are cosmetic or permanent. It's fundamentally important for physicians to be in control of health care."

"We're going to be watching this very closely," agreed RPC Vice President Frank Nicolosi, MD. "We're not giving up, we're just saying let's not go to war just to go to war. I feel happy we had a positive impact and made a lot of gains. But there have to be checks and balances."

The petition for election will be renewed by the end of the year if the RHS weakens its commitment to becoming a physician-led organization, according to the council. ■

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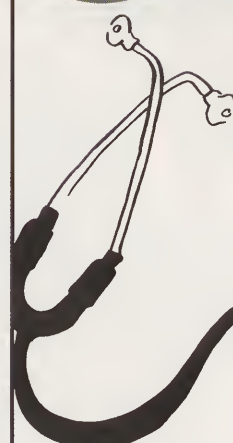
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Saluting the ISMS award winners



MARY ANN STOFFEL (left) of Moline won the 1998 ISMS Non-physician Public Service Award for her tireless work with the Rock Island County Medical Society Alliance's mini-internship program.

MYLES CUNNINGHAM, MD, (below left) of Evanston receives the 1998 ISMS Physician Public Service Award from ISMS past Chairman M. LeRoy Sprang, MD (right). Dr. Cunningham has been a longtime leader in the fight against cancer.



Photos by John McNulty

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Medical Society

(Continued from page 1)

to a local public health department. The reporting process would follow the same practice used for 60 other infectious diseases including AIDS, said IDPH spokesperson Tom Schafer. Individuals testing positive would receive counseling and information about HIV-related services. They would also be encouraged to notify sexual or needle-sharing partners, a method that will greatly help public health officials to stop the spread of this disease, Schafer said.

Local health departments would report HIV cases to IDPH using a number, but not a name. Schafer said that the proposal would help eliminate duplication, creating a more accurate system to track HIV trends.

Ram Yogeve, MD, medical director of the pediatric and maternal HIV section at Children's Memorial Hospital in Chicago, said he has changed his position on this issue and now favors the proposal. "For years I was against reporting by name, but recent changes in the scope of the disease and the need for early intervention caused me to re-evaluate my position," he said during the hearing. However, he added that any change in regulation must ensure the protection of HIV-infected individuals and link to medical care so a patient's quality of life can be improved.

The proposal is up against hearty opposition from organizations and individuals who fear mandatory name reporting would deter people from seeking counseling and testing. Scott McCallister, MD, infectious disease specialist at Illinois Masonic Medical Center in Chicago, said his experience working with AIDS and HIV-infected patients indicates that anxiety about HIV testing would greatly increase if the rule were implemented. Dr. McCallister said he recently treated a patient who admitted delaying testing even when he had HIV symptoms. "Name reporting would add one more obstacle to people already anxious," he said.

Mandatory name reporting may put HIV patients at risk of discrimination and intensify fears of government-sanctioned breaches of confidentiality, asserted Mark Ishaug, AIDS Foundation of Chicago associate director for policy and programs. Ishaug urged the state to convene a task force to explore data collection systems that don't require name reporting.

Dr. Geline agreed that it is important to respect patients' rights and protect their confidentiality. For that reason, even though ISMS adopted a policy in favor of HIV name reporting in 1994, it did not immediately ask IDPH to implement it. "We waited until we could secure improvements to the confidentiality provisions in Illinois statutes that prohibit discovery of these records in civil actions," he said.

Concerns that name reporting would discourage some people from seeking testing and getting treatment are understandable, Dr. Geline said. "But, research shows they have little to fear," he added. "A government survey found that just 1.4 percent of all HIV-positive indi-

viduals delayed testing because of the reporting systems in their states."

Thirty-one other states, including neighboring Indiana, Missouri and Wisconsin, already collect this information, Dr. Geline testified, adding that the Centers for Disease Control and Prevention has urged Illinois and other states to mandate HIV name reporting. He said such a move would allow public health authorities to link HIV patients to necessary health care services, ensure they receive follow-up counseling, including partner notification services and provide more accurate data to track and fight the epidemic.

The Society recommended that IDPH change its proposal to retain the plan to require a sample written consent form. "Written consent for testing is still required in some situations," Dr. Geline said. "The sample form has been a valuable tool for physicians in documenting consent for HIV antibody testing."

The Chicago meeting was one of two hearings held by IDPH to take comment on the proposal. The other hearing was conducted May 4 in Springfield. The state received thousands of comments, said Schafer, who estimated that responding to them will take through the summer. Following the hearings, IDPH Director John Lumpkin, MD, agreed to convene a working group that can make suggestions for a better way to handle HIV reporting. IDPH will submit comments it receives and its own responses to the Legislature's Joint Committee on Administrative Rules, which will check that the rule change does not overstep the department's statutory power. Following legislative review, IDPH will open a second comment period before making a final decision on the rule.

*HIV must be
attacked as a
public health
problem.*

Patient

(Continued from page 1)

grateful for the bipartisan support. "This is not a political issue, this is a people issue," she said. "I couldn't have done it without them."

Two Democrats voted against the bill: Rep. Joel Brunsvold (D-Rock Island) and Rep. Frank Mautino (D-Spring Valley); one Democrat voted present: Rep. Eugene Moore (D-Maywood). Rep. Gary Hannig (D-Gillespie) was absent from the vote.

The legislation prohibits the transfer of liability from health plans to physicians. An amendment requires complaints be brought to arbitration before they go to court. The bill also bans gag clauses, gag practices and retaliatory actions. It also sets up fair and timely channels for resolving patient grievances, and requires timely access to primary care and specialty physicians of the patients' choice.

ISMS pressed hard to rally legislators behind the House bill, Dr. Geline said. Members were urged to contact their legislators and tell them that Illinois physicians will not allow their patients' rights to be held hostage to insurance special interests.

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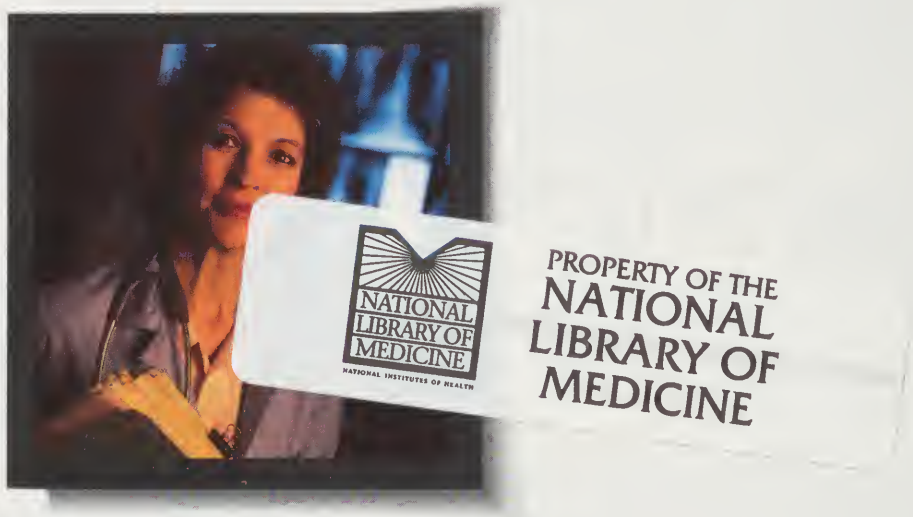
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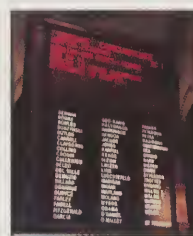
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Ironing out the Sunbeam mess

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Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • JUNE 12 1998



The 1998
legislative scorecard

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Patient rights reform stranded until fall

NEXT UP: Proponents look hopefully to November veto session for revival, passage. BY LINDA MAE CARLSTONE

[SPRINGFIELD]

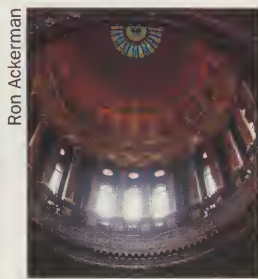
The good news is that the House and Senate both passed managed care reform bills before the Illinois General Assembly adjourned last month.

The complication is that they each passed different versions of reform, leaving patients in limbo as they wait for comprehensive protection against managed care abuses.

Reform proponents, however, including Rep. Carolyn Krause (R-Mount Prospect), called the outcome a progressive step, one setting the stage for victory in the fall or next year. "It indicates there's support in both houses," she said. Proponents next pin their hopes on the veto session scheduled to convene Nov. 5. If the House concurs with the Senate, or vice versa, a bill will move on to the governor for signing.

ISMS President Richard Geline, MD, praised the passage of both bills as a step in the right direction. "The Legislature made a courageous and historic move toward curbing managed care abuses and assuring every patient's right to quality care," he said.

Analysts predict the timing of the veto session, on the heels of the Nov. 3 election, will work in favor of reform. "This will be one of the major issues in the fall campaign season," predicted



Ron Ackerman

Sen. Tom Walsh (R-Westchester), a key leader in developing the Managed Care Patient Rights Act that passed the Senate. Voters will be asking candidates where they stand, which will jack up

the pressure for them to back a managed care reform proposal, he said. "There is a good chance the Senate bill will be embraced by both gubernatorial candidates."

Managed care will definitely be part of statewide and district legislative campaigns, agreed Krause. Even if candidates don't offer a position, it will likely be brought up to them, she said.

The tale of the two bills began in the House, which last year – and again this year – passed comprehensive managed

care reform legislation. However, the bill passed by the House this spring, S.B. 1904, died in the Senate Rules Committee. Opponents said it was too broad, costly and involved too

much government interference. The bill carried an amendment driven by the Illinois Trial Lawyers Association, and supported by ISMS, that would have allowed patients to sue

their managed care plans when care is inappropriately denied.

The Senate developed its own Managed Care Patient Rights Act that Walsh said was an attempt to find middle ground between patient and physician interests versus business and insurance interests. Ultimately, it was supported by ISMS. Consumer groups ended up divided on the bill, which
(Continued on page 14)

Something to savor – but not the whole enchilada

[SPRINGFIELD] Although the General Assembly fell short of serving up a full-fledged managed care reform bill this spring, it did offer a portion of the patients rights menu.

A three-pronged bill to heighten patient awareness of access to Ob/Gyn benefits and to mandate coverage related to cancer screening and diabetes is on its way to Gov. Jim Edgar for approval. The bill requires all insurance and managed care plans to notify female enrollees about their right to choose between an Ob/Gyn or a primary care physician as their principal health care provider.

The push for notification arose after state officials received repeated consumer complaints

that their health care plans were rejecting requests to access their Ob/Gyn directly, revealed Rep. Rosemary Mulligan (R-Des Plaines), chief sponsor of the bill.

"We wanted to clarify the law so that the companies would have to tell women they are allowed a choice, and would have to spell out how the process works," she said.

Another part of the legislation mandates coverage for education, training and equipment for self-management of diabetes. The bill would also mandate insurance coverage for some colorectal cancer screening.

Edgar is in the process of reviewing the bill and has not stated a position on the legislation.

Nurses' bill built on ISMS principles

APPROVED: Legislation ensures physician involvement in care. BY JANE ZENTMYER

[SPRINGFIELD] Illinois will be the last state to legally recognize advanced practice nurses if Gov. Jim Edgar signs a licensure bill the General Assembly sent to him in the session's closing days. The final bill adheres to ISMS' principles.

"By guaranteeing that advanced practice nurses work in collaborative relationships with doctors, this bill will protect the quality of health care and expand access to it in our state," said ISMS President Richard Geline, MD. "Patients should be assured that fully trained physicians will take active roles in providing their care."

The bill, S.B. 1585, reflects months of negotiations between ISMS and the nurses' groups. The ISMS Executive Committee, the ISMS Council on Education and Health Workforce, and medical specialty groups reviewed various proposals and suggested



Ron Ackerman

Karpiel sponsored the ISMS-endorsed advanced practice nurses licensure bill passed in the closing days of the Illinois General Assembly. The measure, which further protects quality health care in the state, awaits Gov. Edgar's signature.

acceptable changes throughout the session-long negotiating process. The ISMS Governmental Affairs Council also reviewed the bill and recommended its support to the ISMS Board of Trustees.

The agreed-upon bill licenses nurse practitioners, clinical nurse specialists and nurse midwives. Nurse anesthetists, however, are not included.

Negotiators failed to agree on the terms for licensure of nurse anesthetists by session's end. Instead, the bill calls for the

creation of a legislative task force that will review the outstanding issues and make recommendations to the General Assembly by April 1999.

"We are pleased to accomplish this goal, which we've been working toward for years," said Linda Roberts, president of the Illinois Nurses Association. "While we are disappointed that we could not reach agreement concerning nurse anesthetist practice, we are thrilled to achieve recognition and licensure for nurse practitioners, nurse midwives and clinical nurse specialists."

Some of the initial proposals from the nurses gave APNs too much freedom, said Sen. Doris Karpiel (R-Roselle), the bill's lead Senate sponsor. However, she said that the compromise
(Continued on page 13)

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Children's
health insurance
bill update

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DEPARTMENTS

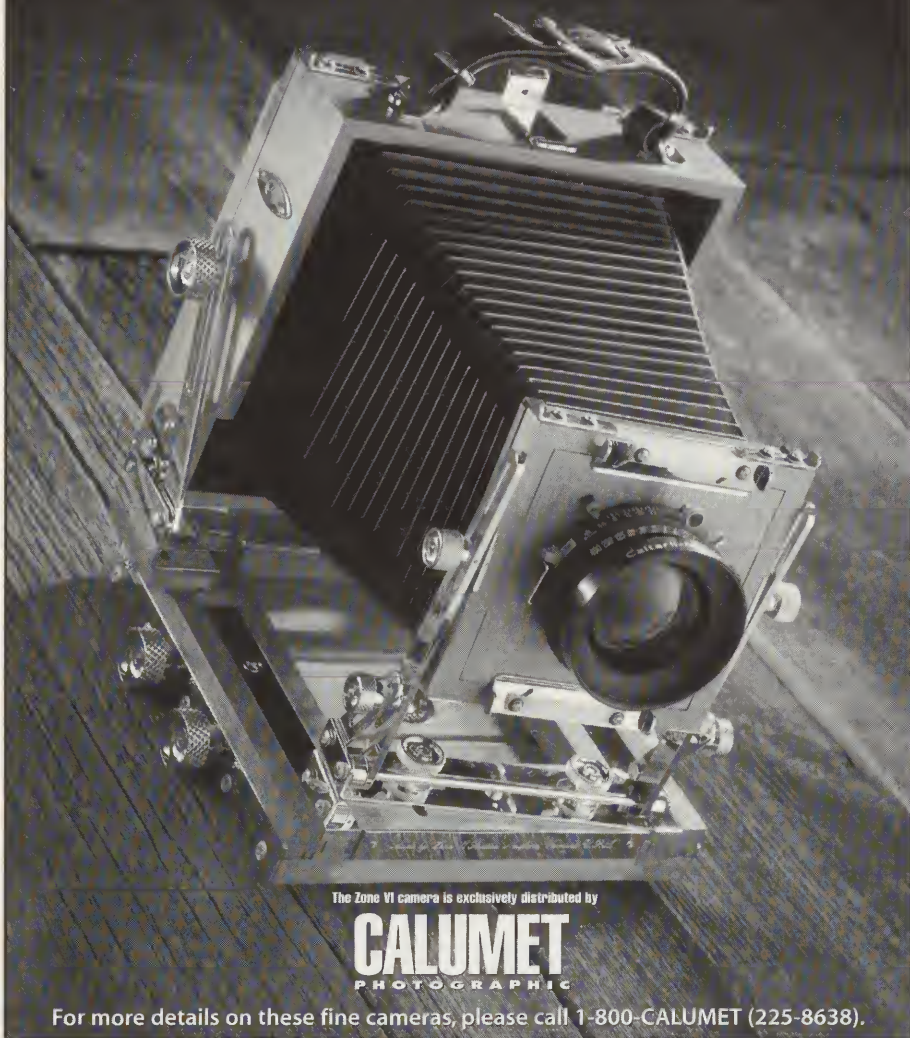
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Ironing out the Sunbeam mess

AMA ANNUAL MEETING: Society prepared to press its agenda.

BY LINDA MAE CARLSTONE

[CHICAGO] ISMS delegates will steam into the upcoming American Medical Association Annual Meeting armed with 21 resolutions they want the association to back — several in response to last year's ill-fated marketing pact with Sunbeam Corp. The AMA meets June 14-18 at Chicago's Hyatt Regency.

"The AMA is in the process of re-evaluating itself, and we are bringing input from our delegates," said Edward Fesco, MD, chairman of the ISMS delegation to the AMA. High on the ISMS agenda are proposals to revamp how the AMA serves physicians, he said.

Several ISMS resolutions demand greater accounting from the AMA as it struggles to recover from the Sunbeam upheaval. Specifically, ISMS wants ongoing reports on any expense related to the debacle. Reports should include — but not be limited to — severance costs of terminated employees, legal costs of investigating and arguing court cases, and all final settlement costs. Currently, the AMA is facing a breach of contract lawsuit filed by Sunbeam.

Among other proposals, the Society wants the AMA to open all board, council, advisory committee and subcommittee meetings to AMA members.

Will the AMA listen? Dr. Fesco

likened the association to a lumbering tanker that requires seven miles to make a turn. "The AMA is slow. They do not respond well. But hopefully we're near the end of that turn."

Sunbeam is expected to be a high-profile issue at the gathering. Delegates will hear a report recommending a clear definition of the roles and responsibilities of the board, chairman and president to ensure such incidents aren't repeated. Due to high interest, the report — prepared by an Ad Hoc Committee appointed by the House of Delegates speaker — is scheduled for consideration at 1:30 p.m., June 14, when no other business is slated to be conducted.

Unwieldy E&M documentation guidelines are another thorny issue ISMS wants the AMA to address.

ISMS opposes mandatory implementation of the guidelines and urges the U.S. Health Care Financing Administration to develop appropriate, rational and voluntary guidelines for documenting E&M services. HCFA recently delayed implementation of a controversial set of mandatory guidelines. "These abhorrent regulations have been put in limbo, but they are not gone," Dr. Fesco said.

The Society agenda also seeks to set AMA policy stating that physicians not be subjected to sanctions for the economic mixture of their patient base; that physicians have access to performance profile information at least annually from organizations retaining such data; and that a standardized explanation of benefits form for all third-party payers be made available. ISMS will also join other states in advocating alcohol control and the nonuse of tobacco, according to Dr. Fesco.

The gathering will also provide the first look at the AMA's new chief executive, hired in the aftermath of Sunbeam. E. Ratcliffe Anderson Jr., MD, a former U.S. Air Force Surgeon General and current chief executive officer of Truman Health Systems, assumes the AMA helm later this summer.

All AMA members, including ISMS members, can speak at reference committee hearings. Similar to the ISMS Annual Meeting, issues at the AMA first go to a reference committee hearing, then to the House of Delegates for debate and vote on the floor.

More than 200 resolutions are expected to be considered. The ISMS delegation comprises 21 of the 484 delegates of the House. ■

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Legislature sends children's health plan to Edgar

INSURANCE: Some copayments and premiums required. BY JANE ZENTMYER

[SPRINGFIELD] After a bipartisan task force spent months hammering out the details, an Illinois children's health insurance plan emerged in the final month of session, just in time for legislators to approve the plan and send it to the governor. The plan, dubbed KidCare, would cover more than 200,000 children from low-income families.

"Good health is crucial to a child's ability to learn in school and realize his or her full potential in life," said Gov. Jim Edgar, who joined with legislators and children's advocates to introduce KidCare at a May news conference. "This agreement on KidCare means better health and brighter futures for nearly a quarter-million children in Illinois."

The state created the Children's Health Care Task Force — comprised of Republican and Democratic legislators, representatives from state agencies, health experts and children's advocacy groups — after the federal government set aside funds for state-run children's health plans in the Balanced Budget Act of 1997. "We look forward to the state being successful in extending needed coverage to more children," said John Schneider, MD, chairman of ISMS' Third Party Payment Processes Committee and a task force member.

Children under the age of 19 become eligible for the program if their household income falls between 133 percent and 185 percent of the federal poverty level, the governor said. That means children from a family of four would qualify for coverage if their household income is between \$21,879 and \$30,433.

Children can receive health benefits through a state-administered plan patterned after Medicaid or through a parent's employer-sponsored plan via a state subsidy that offsets participation costs. Under the first option, the benefits available to eligible children will be the same as those provided by the Medical Assistance Program, and physicians will be paid at Medicaid reimbursement rates. The state expects at least 157,000 children to take advantage of this option, the governor said.

No copayments will be charged for immunizations or preventive care. Other services may require copayments, but families will not have to pay more than \$100 annually toward those copayments. Families between 133 percent and 150 percent of the federal poverty level would not have to pay any premiums, but would have to pay \$2 for each medical visit or prescription.

Families between 150 percent and 185 percent of the federal poverty level must pay a monthly premium of \$15 for one child, \$25 for two children and a maximum of \$30 for three or more children. A medical visit will cost \$5, prescriptions will cost \$3 for generic and \$5 for brand-name drugs, and a non-emergency use of the emergency room will cost \$25.

KidCare's second option is expected to benefit an additional 52,400 children by subsidizing their participation in their parents' employer-sponsored health plan. The subsidy cannot exceed what the state would have paid for the child to participate in the state plan. Although the employer's health plan doesn't have

to meet federal coverage requirements, it must include comprehensive major medical coverage with physician and hospital inpatient services. Families are also responsible for the plan's cost-sharing provisions.

"It's a unique approach," said Rep. Carolyn Krause (R-Mount Prospect), a task force member. "Some [low-income] working families already have insurance, and they do not want to drop that insur-

ance and shift over to the state plan."

The U.S. Health Care Financing Administration must sign off on the Illinois plan before it can be implemented, according to an ISMS analyst. Also, the Illinois Department of Public Aid, which is responsible for administering KidCare, must complete a study that gathers specific information about the eligible children and the potential costs of the program.

KidCare is not considered an entitlement program because the number of children who can enroll is limited to the amount of the money the state appropriates for the plan. For fiscal 1999, the governor has budgeted \$117 million, including state and federal funds. The plan has a sunset date of July 2001, which means legislators must reapprove KidCare by that date in order for it to remain on the books.

In January, Edgar implemented the first part of KidCare by expanding Medicaid's requirements to include an additional 40,400 uninsured children and 2,900 pregnant women. ■



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Admission Criteria

Patient has significant hyperglycemia *associated with* documented dehydration, acidosis, serious infection, or impaired consciousness. Patients with outpatient glucose > or = 600 should be admitted.

Note: Some patients can be hydrated orally or intravenously in the office/urgent care center/emergency room. Follow-up fingerstick glucose may reveal that admission may not be medically necessary.

Optimal Length of Stay

23 hour stay if no diabetic ketoacidosis (DKA);
2 days if DKA or admitting glucose > or = 600

Day 1

Acute problems are aggressively corrected. The patient is ambulated when symptoms stabilize. Diet is reassessed and advanced as tolerated. The patient is discharged the same day discharge criteria (below) are met.

Day 2/Subsequent Day

The patient is discharged the same day discharge criteria (below) are met.

Discharge Criteria

Glucoses trending < 300 with relief of symptoms which caused admission, acidosis and dehydration corrected; afebrile.
Patient taking oral fluids and food for 4 hours;
Patient requiring discharge on long-acting insulin should have a glucose value <300 and >100 at time of peak insulin action (e.g., 4 pm). *It is not medically necessary for all glucoses to be < 300 to meet discharge criteria.*

Note: Diabetic education should start within 12 hours. Diabetic education is a process that is to be continued with home/office follow-up within 2-3 days of discharge.

Case Management/Disease Management Focus

Local number of American Diabetes Association chapter is provided for patients to obtain educational brochures. Home Health, Blue Cross Blue Shield/pathway participation, option of diabetic teaching classes, and whether these are in benefit, is clarified to patient.

Patients are urged to follow-up closely with PCP to discuss chronic disease management issues:

Related cardiovascular risk factors: hypercholesterolemia, smoking, hypertension, lack of aerobic exercise, obesity.
Glycohemoglobin and possible patient self-monitoring of blood glucose;
Annual eye exams;
Routine PCP visits 2-4 times/year, with annual urine test for early detection of kidney disease (microalbumin),
Foot exam every visit

Reference

Standards of Medical Care for Patients with Diabetes Mellitus, Alexandria, VA: Am. Diabetes Assn., Diabetes Care (1996) 19 S1- S118

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EDITORIAL

It ain't over 'til it's over

That noise you heard last month should have been familiar: It was the sound of managed care reformers taking a deep breath as they prepared to learn the fate of two new managed care bills that passed separately through the Illinois Senate and House.

ISMS applauds the courage and tenacity of the lawmakers who made certain these important bills passed. It's imperative to thank those who supported organized medicine, particularly in the last weeks of the state's General Assembly. Just the act of passing two managed care bills was heroic in and of itself. Many times reform bills have stalled in committee or never reached the respective floors of the individual legislative houses, so the passage of two such bills is monumental. The fact that bipartisan support drove these bills to their passage only adds to their luster.

But, as Yogi Berra once said, "It ain't over 'til it's over." At least one bill must survive the veto session that begins Nov. 5 – and the General Assembly must hammer out which bill will go to the governor's desk. If the House concurs with the Senate, or vice versa, one of the managed care bills can move on. If neither house consents to the other bill, which can happen, the bills could both die.

In the next five months, lawmakers on the campaign trail will face considerable

pressure from voters to do something to pull in the reins on managed care abuses. As longtime ISMS supporter Rep. Carolyn Krause, a Mount Prospect Republican, said, even if candidates for the legislative and gubernatorial races don't have positions on managed care reform, voters will be sure to ask about them. Voters' minds are on the effects of managed health care.

Lawmakers must be reminded that these bills are not physicians' bills – they're patients' bills. For example, because of new prudent layperson's requirements in the bills, patients no longer have to jump hurdles to get emergency room care. It's also important to remember that, according to the Kaiser Family Foundation, most managed care reform packages would lead to premium increases that are modest at best. What's good for patients is also good for physicians, businesses and health plans.

ISMS members deserve commendation for their efforts in contacting their own lawmakers to support these landmark managed care reform bills. This is some of the most important legislation the General Assembly will face. It's critical that one of the bills successfully makes it to the governor's desk.

Call your legislators who supported reform and thank them – and remind them that the fight for patient rights is not yet over.

PRESIDENT'S LETTER

Lessons of the Rockford experience

Richard A. Geline, MD



We can predict the course ahead will not be easy.

One of the most closely watched stories both statewide and nationally has been the ongoing evolution of the Rockford Physicians' Council. Recently, the RPC notified the National Labor Relations Board that it was deferring its petition for an election to gain certification as the negotiating agent of the physicians employed within the Rockford Health System.

The story began more than three years ago when the Rockford Clinic became a part of RHS. Gradually, a group of more than 170 physicians – all employees – felt the onset of changes in their ability to practice medicine. Accordingly, they formed the RPC and announced such goals as restoring the integrity of the physician-patient relationship and the role of the physician as the advocate for the patient, and becoming involved in departmental budgeting, operations and staffing, as well as systemwide utilization and quality. The ISMS Board of Trustees supported the efforts of the Rockford physicians, and the AMA provided considerable help through its Office of Physician Representation.

A petition calling for a vote to identify the RPC as the collective bargaining agent for the employed Rockford physicians was distributed, and it qualified for submission to the NLRB. In the fall of 1997, the council filed a complaint that alleged the RHS tried to discourage physicians from supporting the organizational efforts. The NLRB determined in favor of the council in January.

Through the spring, the RHS instituted a number of important changes in response to the organizational efforts. Officials announced that RHS would become a physician-led organization by increasing physician representation on the board of directors, creating a physician-held position of chief operating officer, granting physicians the right to validate the selection of department heads and setting up an advisory system council and an operations council that included physicians.

Seeing these important reforms developing, the RPC deferred its petition to hold a formal election to gain certification as a collective

bargaining agent. Should adequate progress and institution of reforms fail to be made, the organizing process can reactivate.

What can we as physicians learn from the experience of our Rockford colleagues? A number of points become quite clear. First, physicians need to coalesce – a carefully chosen word that means to include all types of physicians coming together. As health care delivery channels through larger entities, including HMOs, hospital groupings and insurance conglomerates, physicians must have one powerful voice to protect our role as patient advocates.

Coalescence can work to the benefit of physicians and patients. The voice of physicians speaking together must be heard by all parties. On the other hand, the lonely voice of the solitary physician in today's environment is like sending David against Goliath without his sling and his stone.

We need to learn to relinquish some autonomy as the managed health care experiment continues. This is not a pleasant thought, but it is essential.

We can look forward to more cases throughout the country similar, if not identical, to the Rockford story. At present, only about 30,000 physicians out of a nationwide total of 700,000 belong to unions, and the majority are residents in training. The process of coalescence is only starting and has not ended with the RPC announcement. Debate will always exist among physicians about collective bargaining. Opinions vary from my colleague who said he was ready to join a union now, all the way to the opinion of another colleague who stated, "Under no circumstances will I join a union and engage in a strike."

We can predict the course ahead will not be easy. The professional and financial stakes are enormous. We need courage, tenacity, vision and faith that our traditional role as professionals and patient advocates is well worth whatever effort is called for as our health care delivery system continues to evolve.

GUEST EDITORIAL

A new judicial imperialism

By Dick Thornburgh

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Tort reformers are taking heart. In state legislatures, 1998 seems likely to bring some common sense back into our legal system. In Florida, legislators are sending the governor a comprehensive tort reform package. In Missouri, reform-minded legislators, led by Assemblyman Pat Kelley, are working to limit venue-shopping, a problem plaguing that state as trial lawyers bring cases in jurisdictions known to hand down big damage awards. The trial lawyers argue that judges and juries outside their favored courtrooms are not "equipped" to handle complex litigation.

Yet just as the legislative tide is turning, signs mount that the tort war has entered a new phase – with troubling implications for those of us who worry about the power of the judiciary. Tort reform victories in state legislatures are being undone in the courts, as state judiciaries aggressively substitute their own notions of what the law should be for the will of the people as expressed by their elected representatives.

The most recent evidence of this new judicial imperialism comes from Kentucky, where last month the state Supreme Court struck down a punitive-damages reform measure that had been on the books since 1988. Writing in dissent, Justice William Cooper observed that nothing in Kentucky's Constitution "transfers the power to formulate public policy in the area of tort law from the legislative department to the judicial department. We, like Bonaparte, have placed that crown on our own head."

Unfortunately, the Kentucky court's action is part of a trend. It follows two cases handed down by the high courts of Illinois and Ohio that suggest that tort reform is coming undone almost before the legislative ink is dry.

In December, the Illinois Supreme Court struck down that state's Omnibus Tort Reform Act, passed in 1995 with bipartisan support. The imperial sweep of the Illinois ruling was astonishing. The court became the first to declare unconstitutional a legislative decision to abolish joint and several liability – the doctrine under which a party deemed just 1 percent responsible for damages resulting from a defective product or negligent act can be held responsible for 100 percent of the damage award. While only one part of the law was found unconstitutional, the court struck down the entire act, ignoring legislation that says a finding of unconstitutionality in one part of the statute does not affect its other portions. Thus, three years after the elected officials of Illinois thought they had enacted tort reform, Illinois's legal system remains unchanged.

In Ohio, the state Supreme Court in February granted the Ohio Academy of Trial Lawyers' request for an injunction against the tort-reform bill passed by the

Legislature last year. The court also agreed to let the trial lawyers' case against the reform bill move directly to the state Supreme Court, skipping over the usual trial and appeals court processes. Should the Ohio Supreme Court rule the bill unconstitutional, the tort reform bill

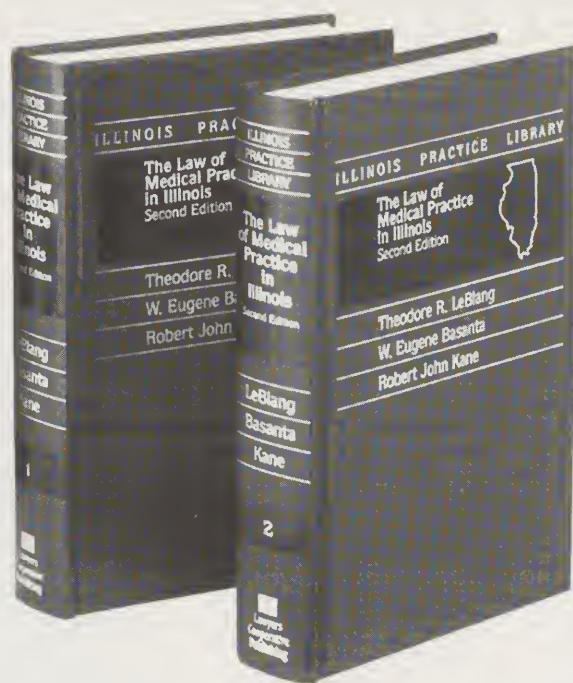
will be killed outright, with no avenue of appeal. When state Attorney General Betty Montgomery filed a motion for discovery to challenge the trial lawyers' standing to sue, the court turned her down.

More than 200 years of judicial history suggests that it is wrong for courts to act this way, especially in the field of tort law, long recognized as an area where legislatures take the lead and to which courts are expected to defer. One of the first legislative acts of the American colonies upon becoming states, and later for territories ascending to statehood,

was usually a "reception" statute – receiving the common law as the basis for the state's tort law. Reception statutes routinely delegate to the courts the authority to develop tort law in accordance with the public policy of the state, which is determined by the Legislature.

Today, however, state courts increasingly substitute their own policy predilections for those of the Legislature. In the past decade, state courts have nullified 73 tort reform laws. The founders' ideas about judicial deference to the will of the people as expressed

(Continued on page 6)



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Judicial imperialism

(Continued from page 5)

through their legislatures are today obsolete notions in many state courts.

It is clear where this judicial imperialism will lead. Witness Alabama, infamous as the capital of lawsuit abuse. A decade ago, the Legislature provided some early victories for tort reformers. Then the state's high court — elected with heavy support from the trial lawyer lobby — began chopping away until the laws were rendered judicially meaningless.

Not surprisingly, this impulse toward judicial muscle-flexing has found an avid

ally in trial lawyer lobbies in other states. Having lost in the Legislature, trial lawyers turn to what they do best: litigation. In Illinois, for example, their road to victory began not with one omnibus challenge to the tort reform bill but with a many-fronted attack of 12 separate cases challenging individual provisions. Then they bundled together individual victories at the trial level into an over-reaching argument that the bill as a whole was unconstitutional.

In Ohio, the trial lawyers' association challenging the state's tort reform act did not file multiple suits — or even begin at the trial level. Instead, they filed a

motion that leapfrogged over the trial phase altogether and landed directly in the state Supreme Court. While tactically quite different, the effect in Illinois and Ohio has been the same: Tort reforms passed by the legislature and signed by the governor have been nullified with no place left to appeal.

Having tasted this kind of power, it's unlikely that the courts in question will willingly return to practicing something more like judicial restraint. Instead, courts that insert themselves into the political process by behaving like super-legislatures will find themselves subject to other forms of political heat. Look for

more Rose Bird-style campaigns to unseat imperialist judges in states where the judiciary is elected, and heightened pressure to influence the judicial appointment process in states where it is not.

The ultimate implications of judicial imperialism echo far beyond tort reform alone. When courts set themselves up as superlegislatures, it isn't just elected legislators who lose. Ordinary citizens lose their power to express their will in the way they are governed. And that, most of us would agree, violates the central feature of what we call democracy.

Thornburgh served as attorney general under presidents Reagan and Bush.

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ISMIE Update

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Laparoscopy and liability: avoiding the risk

BY JEFF BLACK

While laparoscopic cholecystectomies are becoming more and more popular, that popularity is quickly being translated into added physician risk. The following case highlights several issues central to laparoscopy and liability, including patient selection, informed consent, postoperative care and documentation.

The case in brief: Diagnosed with acute cholecystitis, a 39-year-old patient with a history of pulmonary problems and tending toward obesity insisted on a laparoscopic cholecystectomy. She'd heard laparoscopy was less invasive and required a shorter recovery, which, as a single mother, she preferred. Her physician concurred and did not discuss other options. Nor did he mention this would be only his third laparoscopic procedure.

During surgery, the patient's size and the discovery of adhesions complicated visualization, and her common bile duct was severed. The physician converted to an open cholecystectomy and performed an anastomosis.

The patient soon showed signs of jaundice and sepsis. Although suspecting bile leakage

(not documented in the patient's file), the physician treated her for postoperative infection. After no improvement, tests confirmed bile leakage. Shortly after, the patient died of complications from sepsis and congestive heart failure.

The physician was sued for performing a laparoscopic cholecystectomy on a high-risk patient and for inadequate postoperative care. A jury found against the physician.

The points this case makes: As chairman of ISMIE's Risk Management subcommittee on Laparoscopic Cholecystectomy, Edward Fesco, MD, a general surgeon in La Salle, supports laparoscopy, but only if certain strict standards are met, he said.

"The patient may very well have insisted on laparoscopy, but it was incumbent on the physician to explain the dangers," Dr. Fesco said. "He didn't mention that in case of complications he would switch to an open procedure. The patient should have been made aware of many other things, including that any gallbladder surgery is hazardous."

Kevin Glenn, attorney with Bresler, Harwick and Glenn in



*Whatever
you're thinking,
document it.*

Chicago, agreed, adding, "It is axiomatic that the patient does not dictate medical care. They act on the physician's knowledge, not on the patient's desire." In this case, Glenn said, the physician's knowledge should have told him that "this patient is simply not a candidate for a laparoscopic cholecystectomy. She's obese. No laparoscopy. Period."

Glenn added that "although laparoscopic techniques are taught academically, doctors learn by doing. As part of informed consent, you need to reveal when you studied laparoscopy, how many procedures you've done. Most patients will ask, but if they don't, it's up to you to disclose

that information. Especially if you're new."

Neither Dr. Fesco nor Glenn faulted the physician's actions during surgery. According to Dr. Fesco, the physician did everything right, converting to an open cholecystectomy when visualization became difficult and the common bile duct was severed. "That's exactly what he should have done," Dr. Fesco said.

Glenn said that in and of itself, the severed duct is not unusual in laparoscopy and not a basis for a claim. But, he warned, "you definitely have to tell patients there's a greater than 10 percent incidence of severing a major duct. When the rate is greater than 10 percent, that's not the doctor," Glenn said. "That's the procedure. So, severing the bile duct is not a deviation from standard of care. Not recognizing it and acting accordingly is."

Dr. Fesco was critical of the physician's postoperative care. "Bile leakage should have been his first suspicion," he said. "Although other things could have contributed to the patient's symptoms, tests should have been run immediately to determine what was going on. Whatever you're thinking,

document it."

Glenn was more blunt. "His postop care was sinful," he said. "He should have immediately ordered a test to confirm bile leakage. Now, he may have suspected other things too. She had other conditions, the obesity, the pulmonary stuff. Maybe he suspected bile leakage, but had good reasons why it wasn't high on his index of suspicions. But explain it in the documentation."

"I tell physicians the standard of care is not perfection," Glenn continued. "The standard of care is your best effort. That's why you must document your treatment plan and your reasons for it. Even if it is the wrong treatment, if your reasons are solid and well-documented then you'll be OK."

To Dr. Fesco, too, thorough documentation is essential, and he sounded a warning to all physicians in all situations: If a physician doesn't document a suspicion, a rationale for treatment, a conversation, he said, "it has to be assumed there was no suspicion, no rationale, that a subject was never brought up."

Case in Point uses hypothetical case histories to illustrate key risk management issues.

MALPRACTICE ROUNDUP

Man blinded by blood clot surgery awarded \$4.72 million

A Michigan jury awarded \$4.72 million to a man who went virtually blind after undergoing blood clot removal surgery, according to the April 20 issue of the National Law Journal.

In *Rekowski vs. Mount Clemens General Hospital*, the patient charged that personnel at the hospital failed to respond to a drop in blood pressure and blood loss, reducing oxygen to the optic nerve. As a result, the nerve was nearly destroyed, the patient's attorney said. The original \$6.75 million verdict was reduced on the jury's finding of contributory negligence. The defense planned to appeal.

Physicians, hospital found not liable for birth injuries

A superior court jury found two California obstetricians and a hospital to be not liable for injuries a baby suffered during birth, according to the May issue of Medical Malpractice Law & Strategy.

In *Stovall vs. Meadows*, the attorneys for the parents alleged that inadequate fetal monitoring led to a failed attempt at a vaginal, forceps-aided delivery that resulted in a hypoxic episode. The baby was subsequently delivered by cesarean

section with Apgar scores of 4 at one minute and 6 at five minutes.

The parents also claimed the baby suffered from several birth-related injuries, including cephalohematoma, subgaleal and subarachnoid hemorrhages, Erb's palsy and phrenic nerve palsy, and continued to have seizures, right-sided hemiparesis and learning disabilities.

The defendants said they acted within the standard of care during the delivery, adding that they resolved most of the baby's injuries within two weeks of birth. The physicians said the hemiparesis and seizure disorder were the result of congenital conditions, not birth disorders.

Internist ordered to pay for failing to diagnose infection

The insurance carrier of a New York internist has agreed to pay \$1.95 million to a patient who said he failed to diagnose endocarditis, which led to a stroke, according to the April 6 issue of the National Law Journal.

The patient came to the internist with various symptoms of endocarditis, said papers filed in *Minella vs. Antelis*. However, the defense argued that extensive testing failed to detect it. Her attorney argued that the physician should have ordered a blood culture, which would have shown the infection.

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JUNE 12 1998

Phillips named distinguished rural health educator

INFLUENTIAL: Physician cited for her work with residents.

[QUINCY] Debra Phillips, MD, of Quincy has been named the National Rural Health Association's distinguished educator for 1998.

The award recognizes a physician's work in rural health, the sophistication of their scholarly effort and the evidence of outcomes in rural health. It also acknowledges Dr. Phillips' dedication to the needs of rural practitioners.

Dr. Phillips is associate professor of family and community medicine at the Southern Illinois University School of Medicine. She is also the associate director of the Quincy Family Practice Residency Program and the medical director of the East Adams County Rural Health Clinic.

"She has been the greatest single influence that has caused a large percentage of graduating residents of the Quincy Family Practice Program to practice in rural areas," said Jerry Kruse, MD, director of the program.

"Since Dr. Phillips has been with the program, 70 percent of our graduates have settled in areas that are not part of metropolitan statistical areas, far above the national average of less than 30 percent for other family practice residencies."

In addition, Dr. Phillips has directed a grant project that led to an interactive



Ron Ackerman

DURING AN ILLINOIS Rural Health Association telemedicine conference in Springfield, Dr. Phillips explains that more and more physicians use new technology.

website for rural physicians and rural family educators. She also teaches electronic medical record keeping to family physicians as a way to decrease their workload.

Dr. Phillips plans to introduce telemedicine into the East Adams County Rural Health Clinic in the future. ■

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“Carrying out our members’ will.”

Now that Illinois lawmakers have closed up shop until November, it’s time to assess how physicians and patients fared this year.

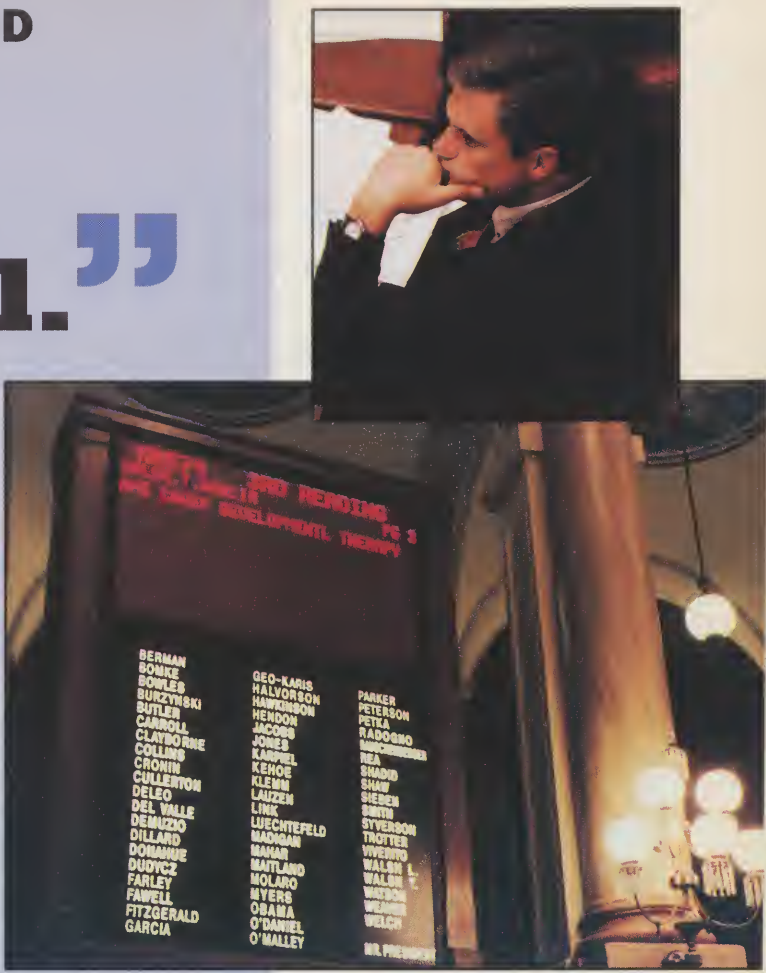
ISMS was crucial to shaping bills identified as key by the House of Delegates, stated Nestor Ramirez, MD, chairman of the ISMS Governmental Affairs Council. “Our job in Springfield is to carry out the will of our members,” he said.

The 1997-98 session was good for health care. Comprehensive managed care bills passed each house, though neither made it all the way. However, a bill licensing advanced practice nurses did get through – but only after it included ISMS’ principles. (See the stories on page 1.)

Other health-care related bills correct infant-care information given to parents, force heightened benefit awareness from managed care and mandate diabetes and some cancer-screening coverage.

Because defeating bad bills is just as important as passing good ones, ISMS worked vigorously to block several proposals detrimental to physicians.

The chart below provides highlights of the Society’s legislative efforts.



Photos: Ron Ackerman

Bill	Summary	Outcome	ISMS' Position
H.B. 705	Insurance – Creates the Children’s Health Insurance Program. (See the story on page 3.)	Passed	Support
H.B. 3427	Insurance – Requires plans to notify women of their right to choose a principal health care provider specializing in obstetrics or gynecology. Mandates coverage for diabetes self-management education and training, and for colorectal cancer screening. (See the story on page 1.)		Support
H.B. 3435	Public Health – Allows hospitals to distribute information that explains to new mothers how to perform CPR, instead of the Heimlich maneuver, on infants.		Support
S.B. 1383	Public Health – Requires the Illinois Department of Public Health to promote awareness and early detection of prostate and testicular cancer.		Support
S.B. 1585	Nurses – Licenses clinical nurse specialists, nurse practitioners and nurse midwives appropriately by ensuring physician involvement in patient care. (See the story on page 1.)		Support
H.B. 2921 S.B. 1253	Nurses – Licensed advanced practice nurses without involving physicians in patient care.	Failed	Oppose
H.B. 3489	Payment – Banned balance billing except for applicable deductibles or copayments when a physician provided services under a contract with an insurance company or HMO.		Oppose
S.B. 1450	Discipline – Required physician profiling with medical malpractice information, proof of liability insurance, staggered license renewal dates and use of National Practitioner Data Bank when reviewing applicants. Allowed public members of Medical Disciplinary Board to vote on disciplinary matters.		Oppose
S.B. 1544	Liens – Limited the total payments of all health providers in a lawsuit to one-third of the settlement or judgment received by an injured person.		Oppose
H.B. 974	Managed Care Reform – Created a comprehensive reform bill called the Managed Care Patient Rights Act, which was initiated in the Senate. (See the story on page 1.)	Passed the Senate, Stalled in House	Support
S.B. 1904	Managed Care Reform – Incorporated managed care reforms from H.B. 626, a reform bill the House passed last year. (See the story on page 1.)		Support
H.B. 2478	Medicaid – Allowed providers, when audited by Medicaid, to offset any under-payments found during the audit against any overpayments also discovered.		Support
H.B. 2645	Insurance – Required plans to include coverage for reconstructive breast surgery performed after a mastectomy and for reconstructive surgery to fix children’s deformities.	Failed	Support
H.B. 2849	Public Health – Banned smoking in restaurants.		Support

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IDPR DISCIPLINES

This information, published as space permits, is reprinted from the Illinois Department of Professional Regulation's monthly disciplinary report. IDPR is solely responsible for its content.

March 1998

Woo Young Kim, Sterling – physician and surgeon and controlled substance licenses probation extended for an additional year for violating the terms and conditions of a previously ordered Department probation.

Luis Munoz, Chicago – physician and surgeon license indefinitely suspended after being terminated from the Medical Assistance Program by the Illinois Department of Public Aid, being excluded from federal Medicare and Medicaid programs, and failure to report those actions to the Department.

John E. Strong, Winfield – physician and surgeon license indefinitely suspended for failure to pay individual income tax returns for the years 1992-1995 and outstanding tax liability owed the Illinois Department of Revenue.

April 1998

Surendra P. Agarwal, Effingham – physician and surgeon license placed on

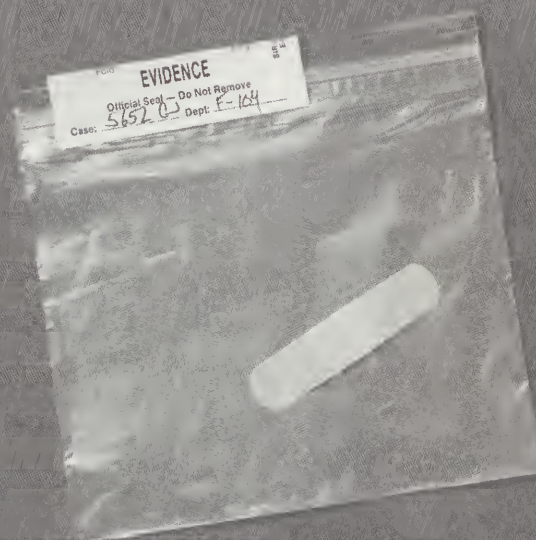
probation for two years and fined \$2,500 for performing skin testing for allergies on multiple patients for financial gain, failing to transfer medical records as required by law, instructing a nurse not to discuss office procedures with the Department, maintaining an office in an unsanitary and unsafe condition, and not complying with all controlled substance record keeping requirements.

Imad M. Al-Basha, Rockford – physician and surgeon license reprimanded and fined \$1,000 for failing to properly document services actually rendered to a patient and erroneously sending a bill which listed services for a date upon which no services were provided.

Jackson Chen, Oak Brook – physician and surgeon license placed on probation for one year and fined \$10,000 and controlled substance license suspended for 90 days for providing medical services to an entity which was precluded from engaging in treatment of patients pursuant to Illinois law, and allegedly failing to follow proper protocols with regard to hospital admission of patients, procedures relating to dispensing of controlled substances and communication with other physicians involved in patient's care.

Exhibit A:

Adhesive bandage, which plaintiff alleges defendant pulled rapidly from skin, violently tearing three hairs from plaintiff's arm, which resulted in severe shock, trauma, disfigurement, chronic debilitating pain and permanent psychological damage.



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The St Paul

Medical Services

United HealthCare, Humana to merge

ACQUISITION: Officials cite intense competition, rising costs.

[MINNEAPOLIS] United HealthCare has acquired Humana Inc. in a \$5.5 billion merger, according to reports from both companies. The combined enterprise will operate under the United HealthCare banner and will be based in Minneapolis, with part of the workforce remaining in Humana's home base of Louisville, Ky. Officials cited rising medical costs and intense competition as reasons for the merger.

The new company will have annual revenues of about \$27 billion, operating in 48 states – including Illinois – as well as doing business in Hong Kong, Singapore and South Africa. Officials have not determined how many of the 30,000 United HealthCare and 20,000 Humana employees would be cut.

By the end of this year, United HealthCare's open access plans will enable nearly 4 million health plan members in

38 markets to see network physicians and specialists without referrals, said William McGuire, MD, the company's president, chairman and chief executive officer. He added that the merger will enhance United HealthCare's six business segments: health plans, retiree and senior services, strategic business services, insurance services, specialized care services, and knowledge and information services.

Humana's chief executive officer,

Greg Wolf, said the new enterprise will reach millions of members in all 50 states, and will take advantage of the organization's new economies of scale and administrative efficiency.

"The merged company will offer greater choice of doctors and hospitals, consumer-focused, high-quality products and the ability to measurably improve our members' health," Wolf said. "A proprietary information system with the capacity to collect and analyze enormous reservoirs of the most current data will be of tremendous value to patients and physicians as they seek the best clinical pathways."

DuVivier wins governor's unique achievement award

[SPRINGFIELD] Edward DuVivier, MD, a retired Godfrey physician, was one of nine winners of the 1998 Governor's Awards for Unique Achievement. The awards were presented through the Illinois Department of Aging as part of Older Americans Month in May.

Dr. DuVivier was a longtime delegate to the ISMS House and served as director of the regional peer review organization for 15 years. In addition, the former president of the Madison County Medical Society has served on the boards for the area Easter Seal Society, the American Cancer Society and the Alton YMCA.

He was nominated for the governor's award by the Southwestern Illinois Area Agency on Aging of Fairview Heights and has served on the organization's board of directors and as a current advisory council member. Dr. DuVivier also served as a delegate to the National Silver-Haired Congress in February in Washington, D.C.

The U.S. Administration on Aging chose the theme "Living Longer, Growing Stronger in America" to draw attention to the remarkable longevity of the population and the challenges and opportunities that will accompany aging in the next millennium, said IDOA Director Maralee Lindley.



Brian Warring

HONORED FOR HIS commitment and pleasant nature, ISMS senior technical services coordinator Tom Van Denack received a recent employee recognition award.

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Nurses' bill

(Continued from page 1)

strikes an acceptable balance and puts into law the relationships many physicians already have with APNs. "This does not allow nurses to independently diagnose and prescribe medicine. I would think that most nurses wouldn't want that kind of responsibility," Karpel said.

The requirement for APNs to have written collaborative agreements with physicians ensures a physician's involvement in patient care. Also, the APN may only provide those services generally provided by the collaborating physician. This would allow, for example, nurse midwives to have agreements with physicians who practice obstetrics, but prevent them from having agreements with physicians who don't practice obstetrics.

As part of the collaboration, physicians must provide medical direction, defined as guidelines and standing orders that are jointly developed and signed by the collaborating physician and APN. Also, the collaborating physician must first delegate prescriptive authority before an APN can prescribe controlled and noncontrolled drugs. Delegated authority can only be given for Schedule III, IV and V drugs; APNs cannot prescribe Schedule II drugs, according to the bill.

ISMS had requested a ratio that would limit physicians to two collaborative agreements with nurse practitioners, clinical nurse specialists and nurse midwives, and four agreements with nurse anesthetists. However, legislators and nurses expressed deep concern about the ratios, pointing out that only three states now have ratios and that another recently repealed its ratios. The lawmakers subsequently asked for an acceptable alternative to strict ratios that would still prevent abuses.

To uphold the spirit of ratios, the bill states the collaborating physician must be in active clinical practice, and also adds two grounds for discipline to the Medical Practice Act. The first would allow the Illinois Department of Professional Regulation to discipline physicians who enter into an excessive number of written collaborative agreements with APNs, preventing them from adequately collaborating and providing medical direction. The second ground would allow a physician to be disciplined for repeatedly failing to adequately collaborate with or provide medical direction to an APN.

To be licensed as a nurse midwife, clinical nurse specialist or nurse practitioner, the bill requires an APN to be licensed as a registered nurse, earn a master's degree within 12 months after adoption of final rules or by July 1, 2001, whichever is earlier, and receive national certification from the appropriate national certifying body. To maintain their license, APNs will be required to complete 50 hours of continuing education during each two-year licensure cycle.

The bill also gives some nurse practitioners the option to be grandfathered. To do so, however, nurse practitioners must apply for the status by July 1, 2001, must have completed a post-basic education program and must have been

in practice for 10 years.

The nurses also agreed with ISMS' proposal to create an Advanced Practice Nursing Board that has the power to review and make recommendations to the Illinois Department of Professional Regulation regarding the licensure and discipline of APNs. The governor is responsible for appointing the nine-member board, which will have four APNs, three physicians and two public members, according to the bill.

"The Medical Society should be commended for its perseverance on this issue," said Rep. Angelo "Skip" Saviano (R-River Grove), the bill's lead House sponsor. By ensuring a physician's involvement in patient care, he said, "the Medical Society and, I think, the Legislature made sure quality of care was always protected."



As the legislative session headed toward adjournment in late May, some lawmakers worked overtime toward improving the state's health care.

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Some physicians need new Medicare numbers

[CHICAGO] More than 600 physicians may need to change their Medicare provider numbers to reflect their practice situation accurately, according to the Illinois Medicare Part B carrier.

Some solo physicians currently have numbers indicating they are part of a group practice, the carrier said in a letter mailed in May. However, because the U.S. Health Care Financing Administration defines group practice as two or more active members, any physician who is the only active member of his or her practice but has a group practice number will need a new number.

To change their numbers, physicians must re-enroll in Medicare as individuals or sole proprietors. Affected practices should have received a letter from the carrier asking them to fill out the necessary forms to change their provider numbers.

For more information, call the carrier's provider certification unit at (608) 221-5678.

Patient rights

(Continued from page 1)

was backed by the American Association of Retired Persons and opposed by Citizen Action and the Campaign for Better Health Care.

ISMS negotiated aggressively on the bill crafted by Senate Republicans. The bill, H.B. 974, passed by a 50-4 vote just hours before the Legislature closed. Three senators voted present and two did not vote. Voting against the bill were Sens. Edward Petka (R-Plainfield), Steven Rauschenberger (R-Elgin), Todd Sieben (R-Geneseo) and Dave Syverson

(R-Rockford).

Dr. Geline congratulated Senate President James "Pate" Philip (R-Addison) and the senators on both sides of the aisle who gave this landmark legislation overwhelming bipartisan support. "The act sets up a common set of ground rules that will standardize managed care practices without imposing the kind of overactive bureaucracy that raises costs unnecessarily."

The act was not called for a vote in the House, however. Krause said she is disappointed that Democrats, who, as the majority party in the House, had control over calling the bill for a vote, did not bring it up. Democratic leaders said they wanted more time to look at it, Krause said. "I am hoping that means it will be taken up again in November."

The two pieces of legislation have many provisions in common, such as restrictions on gag clauses and gag practices, and a ban on plan requirements for prior approval of emergency care.

However, there are some differences in the bills:

- H.B. 974 contains an exemption for ERISA plans, although HMOs, Third Party Administrators and utilization review agents who contract with ERISA plans would not be exempted.
- H.B. 974 requires all plans using utilization review – the process of evaluating medical necessity, appropriateness and efficiency – to adhere to American Accreditation Health-Care Commission/URAC standards.
- Although both bills establish a procedure for a standing referral for patients needing ongoing care from a specialist, only H.B. 974 includes a mechanism to appeal denials.
- Continuity of care for patients undergoing a course of treatment when they, or their doctors, leave the plan is mandated in H.B. 974, while S.B. 1904 allows these services only when there is a life-threatening condition or a disabling disorder.
- Both bills mandate that physicians receive notice of termination; however, H.B. 974 includes a 60-day notice requirement to enrollees of termination of their provider.
- H.B. 974 gives patients the right to choose a primary care physician; S.B. 1904 more simply requires that patients be provided a primary care physician list.
- H.B. 974 prohibits the transfer of liability to physicians who contract with plans; while S.B. 1904 is silent on this issue.

The House has indicated that hearings on the relative merits of both bills will be conducted prior to the veto session. ■

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PAGE 3

High court urged to reverse ruling on mental illness, suicide

LAWSUIT: ISMS joins amicus brief challenging appellate decision. BY JANE ZENTMYER

[SPRINGFIELD] A medical malpractice lawsuit now pending before the Illinois Supreme Court prompted physicians and mental health activists to file a joint amicus brief in May on the legal responsibilities of physicians and patients when a patient commits suicide.

The brief responds to a 9-month-old appellate-court



ruling that, in effect, said no "mentally ill" individual is responsible for his or her own conduct. The court held that physicians cannot rely on legal principles of comparative fault if their patient is being treated because he or she is suicidal. The verdict overturned one in

favor of a defendant physician.

"The courts must recognize that physicians need discretion to provide good medical care in treating patients," said ISMS President Richard Geline, MD, about the Hobart vs. Shin case. "The appellate court's decision could discourage physicians from providing that care and thereby harm our patients."

Hobart vs. Shin stems from the death of Kathryn Hobart, who committed suicide using an antidepressant prescribed to her by both her family physician and psychiatrist as treatment for depression. The patient's family filed a suit alleging that the failure of her family physi-

(Continued on page 2)

ISMS to take the pulse of its members

Do managed care constraints threaten quality patient care? Do you spend excessive hours complying with intrusive regulations? ISMS wants to hear the problems and concerns you and other Illinois physicians face in today's health care climate. A survey will soon be mailed to ISMS members, and we urge you to respond so that your needs can better be met.

Planning for death and dying

DECISIONS: Booklet updated to coincide with new advance directive laws.

BY LINDA MAE CARLSTONE

[CHICAGO] A revised version of a booklet that helps patients plan how their medical decisions will be handled if they are no longer capable of making those choices is now available to Illinois patients. The booklet, titled A Personal Decision, is used widely by physicians and health care facilities to educate patients about their rights and responsibilities in planning for death, dying and incapacitation.

Federal law requires the state to issue a statement explaining its advance directive laws, and the Illinois Department of Public Health's revised statement is included in the new publication.

The new booklet is updated to encompass changes in Illinois law since its 1991 edition. The most recent change, effective last Jan. 1, allows a surrogate to make medical-treatment decisions even when the patient's death is

not imminent. According to Deanna Mool, chief counsel for the Illinois Department of Public Health, which oversees the state's advance directive laws, the revision broadens the circumstances under which a surrogate

can intervene. Formerly, a patient needed a "qualifying condition" - defined as terminal, incurable or irreversible - before a surrogate would be appointed to make the patient's

(Continued on page 8)

"There's always something a doctor can do..."

When it comes to helping terminal patients prepare for end-of-life medical decisions, experts advise physicians to focus on the two Ps: People and Paper.

"The people part stresses the human side of the planning equation - bringing the patient and physician together for a conversation about the patient's preferences and values for treatment," said Andrew Varney, MD, chairman of the Human Values and Ethics Committee at the Memorial Medical Center in Springfield.



Dr. Varney

Dr. Varney said he shudders when he hears people say a patient has cancer and there's nothing else that can be done. "There's always something a doctor can do, even when it's too late to write a

(Continued on page 8)



As part of his Alliance mini-internship, Wheaton Mayor James Carr (left) looks on, fascinated, as otolaryngologist James Lee, MD, examines patient David Schneider.

Andrew Corrigan Halpern

Visiting the front lines of day-to-day medicine

ALLIANCE: Mini-internships offer participants a unique learning opportunity. BY JOHN OTROMPFKE

[BELLEVILLE] John Green Sr., chairman of the Midwest Teamsters health fund, admitted he was hesitant to follow Belleville orthopedic surgeon William Simmons, MD, into the operating room. A participant in the 1998 Illinois State Medical Society Alliance Mini-Internship Program, Green finally consented - after all, that was part of a physician's job. "I watched him remove a tumor from a bone in one arm," he said.

Green left the operating room with more than just a colorful anecdote to tell his family. In addition, he carried away a strong impression of something that many decision-makers in the business of health care don't often see: the one-on-one contact that forms the core of the patient-physician relationship. He also gained a better understanding of the financial ramifications that come with the territory.

Green was one of dozens of individuals who participated in

mini-internships sponsored by several Illinois county medical Alliances in cooperation with the ISMS Alliance. This year, interns took part through medical Alliances in Lake, McLean, Peoria, Sangamon, St. Clair and Winnebago counties. The program, which began in 1991, allows laypeople the chance to experience the life of

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INSIDE

HMO
 tactics
 targeted
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Proposed bills target HMO strong-arm tactics

MAJOR PLAYER: ISMS concern leads lawmakers – inch by inch – toward reform. BY JANE ZENTMYER

[CHICAGO] As managed care companies flex their market muscles, their flaws are becoming increasingly apparent – and troublesome – to physicians and patients. That is why, explained ISMS President Richard Geline, MD, the Society's recent legislative efforts target the strong-arm tactics insurers use to damage patient-physician relationships.

"There have been a number of managed care reform bills proposed in Springfield, starting with our own Managed Care Patient Rights Act, originally introduced in 1996," Dr. Geline said at a May 15 Chicago Health Policy Research Council forum. "We want managed care reform to provide a comprehensive answer to the key question facing patients and their doctors today: In an era of managed care, what rights do patients have?"

MCPRA incorporates five basic patient rights – quality, choice, individual autonomy, confidence and information – that ISMS believes should be a part of any meaningful reform measure, Dr. Geline said.

Although MCPRA hasn't passed, the growing pressure for a reform bill did result in the Illinois House and Senate passing their own separate measures this year. However, the session ended before



John McNulty

Dr. Geline tells health policy forum participants that for every difficult managed care story, there are likely a lot more situations that go undiscussed.

the two versions could be reconciled.

The need for these reforms can be seen in many of the problems the media have highlighted, such as "drive-through" deliveries or mastectomies, and delayed or denied treatments. "For every one difficult story about some dramatic effect

of managed care, there are probably a lot of situations that go unreported and undiscussed," Dr. Geline noted. "It's like an iceberg. There's a little bit on top, above the water. But you know 90 percent of that iceberg is below the water."

"A balance needs to be reached, one recognizing the needs of patients and physicians, as well as the interests of insurance companies," Dr. Geline explained. "We think the most effective way to do that is to work with the Illinois General Assembly to build a solid set of ground rules for managed care – so that competition will be based on quality, not on which plan can drive costs the lowest by eliminating necessary services."

"The Medical Society has been very active down in Springfield," acknowledged Frank Nicholson, immediate past president of the Illinois Association of Health Maintenance Organizations. However, another important player in the managed care reform debate, Nicholson said, is the business community.

Although patients pay a small part of their health care costs, "the people who pay the bills are the employers," he said. "The industry has been driven by the people who pay the bills." Managed care helped control the double-digit increases in health care costs, and many businesses

argue that legislative reforms will translate into higher health insurance costs.

However, Dr. Geline disputed the concern that managed care reform would increase health care costs. For example, the Society's MCPRA proposal calls for all plans to include a point-of-service option, but it allows plans to charge a reasonable fee for that option, adding less than 60 cents to the average monthly premium, according to a Kaiser Family Foundation study released this spring. "That's just pennies a day for the confidence that you'll be able to get the physician you need," Dr. Geline said.

Nicholson also said that the industry has not dealt very well with some of the "humanistic" aspects of medicine, citing the drive-through delivery controversy as an example. In some instances, Nicholson said, physicians tell their patients that their HMO said they must go home. But, he added, "We delegate utilization management. We never tell the physician any patient has to go home," Nicholson said. "Yet we often get calls that the doctor was told by the HMO that a patient must [be discharged]."

Dr. Geline added that while an HMO cannot discharge patients, it can still influence the patient-physician relationship by refusing to pay for medically necessary care.

"We must ask ourselves," Dr. Geline concluded, "if the decision not to pay for something is the equivalent of practicing medicine." ■

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High court

(Continued from page 1)

cian, Daniel Shin, MD, to inform the psychiatrist of the prescription he wrote ultimately gave the patient access to enough antidepressant to commit suicide.

Dr. Shin argued in his defense that the patient's actions contributed to her own death – a legal theory called "contributory negligence." Under this theory, patients can be responsible for part or all of their injuries, and juries are instructed to assign percentages of liability based on the extent they believe plaintiffs contributed to their own injuries, explained ISMS General Counsel Saul Morse.

The appellate court found, however, that the defense "should not be permitted to allege that [the patient] was contributorily negligent for acting in a manner consistent with her disorder."

"By prohibiting this jury analysis," Morse explained, "the appellate court in effect made this an all-or-nothing case. The physician can either be completely not guilty or 100 percent responsible for the patient's death."

The amicus brief, filed jointly by ISMS and the Illinois Psychiatric Society, argues that the appellate court's decision oversimplified a physician's liability for a patient's suicide.

For example, the brief stated the term "mental illness" is too broad to be meaningful. "We don't define all heart diseases as the same," said IPS President-elect Sidney Weissman, MD. "One has to understand the different levels of severities and different kinds of mental illnesses." As detailed by the brief, the law should treat patients with different forms of mental illnesses accordingly.

Patients with mental illnesses also

shouldn't automatically be assumed incapable of making decisions, the brief states. "Even patients with major depression, or certain forms of psychosis, may be legally competent for purposes of choosing whether to inform a physician as to their mental state. Not every 'mentally ill' person can or should be presumed incompetent for purposes of contributory negligence," Dr. Weissman added.

The appellate court's decision also undercuts good therapeutic practice, Dr. Weissman argued, because treatment for some mental illnesses, like depression, includes promoting the patient's responsibility for his or her actions. "By suggesting that all 'mentally ill' patients are not responsible for their actions, the appellate court's opinion glosses over the differences among patients," Dr. Weissman explained. "The opinion not only codifies the stigma of mental illness, but also poses dangers for patients."

Physicians may be afraid to treat potentially suicidal patients if they misread the decision as suggesting physicians can be held legally responsible just because a "mentally ill" patient commits suicide while in the physician's care. "Physicians have a limited ability to predict suicide," the brief argues. "Even with the best of medical care, not all deaths from suicide can be prevented – just as not all deaths from heart disease or diabetes can be prevented."

According to Dr. Weissman, physicians need to use their discretion to treat patients appropriately based on their condition without interferences from third parties. "This is an issue we are facing throughout medicine right now. Medical judgments are being made by others," he said. "In this particular case, it has profound ramifications." ■

State defines PAs' prescriptive authority

RULES: A final version may be ready by late summer. BY JANE ZENTMYER

[SPRINGFIELD] Physicians who have physician assistants, or who wish to hire one, may want to take notice: The Illinois Department of Professional Regulation is fine-tuning a rule that will allow PAs to prescribe drugs under the supervision of physicians.

The rule provides the details physicians need to delegate prescriptive authority to their PAs — a new responsibility only legally given to PAs in last year's revision of the Physician Assistant Practice Act. The final regulatory hurdle is expected late this summer with review by the state's Joint Committee on Administrative Rules. Once adopted by IDPR, Illinois will be among the 42 states that allow PAs to prescribe some drugs.

"I hope that this new rule will make practices run more smoothly for the physician assistant and the rest of the office," said Barbara Miller, president of the Illinois Academy of Physician Assistants. "I also hope that it will create more opportunity for PA employment in areas that may be [medically] underserved at present."

For PAs to have prescriptive authority, their supervising physician must first delegate it. "On an IDPR form, the supervising physician will notify the department when he or she delegates prescribing authority, including authority for Schedule III, IV or V drugs," said John Lopes, chairman of IAPA's legislative committee. The physician can also choose not to delegate any prescriptive authority.

The rule states that physicians "may not delegate authority to prescribe Schedule I and II controlled substances." And, IDPR must be notified if the decision is made to terminate the prescriptive authority. A physician can be disciplined for failing to notify IDPR of the delegated authority or its termination.

The PA's prescribing authority will also be spelled out in written guidelines developed by the PA and the supervising physician, explained Dean Bordeaux, MD, vice chairman of IDPR's Medical Licensing Board, which oversees the Physician Assistant Advisory Board. According to Dr. Bordeaux, any delegated procedure or prescriptive authority must be within the current scope of practice of the supervising physician.

When exercising their delegated authority, PAs must affix their supervising physician's Drug Enforcement Administration number to the appropriate prescription form and individually sign it. The prescription form itself must

contain the printed names of the PA and the supervising physician. PAs will not need their own DEA number, according to the rule.

Physicians have the final responsibility for patient care and the PA's job performance, according to the rule. The physician is also responsible for directing and reviewing a PA's work, records, prescriptions and practice to ensure that

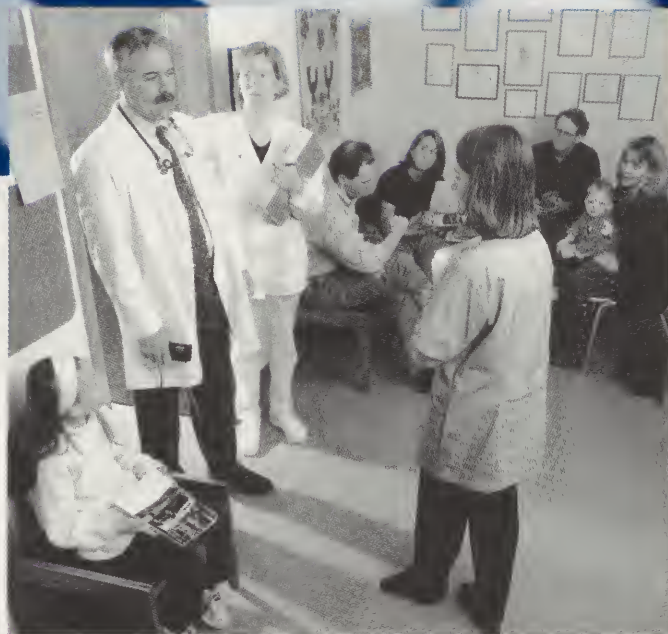
appropriate directions are given and understood, and that appropriate treatment is provided.

Once the rule is implemented, patients may have an easier time getting refills or new prescriptions because they may no longer have to wait for the supervising physician to sign the prescription. This could be especially helpful in rural areas where the PA's

supervising physician may be several miles away. Lopes added, "I know it will help PAs who assist surgeons, because now [PAs] will be able to issue a prescription when a patient is discharged."

The PA's name on the form also clearly identifies for the patient who initiated the prescription, Dr. Bordeaux said, further explaining that it identifies to the government who actually wrote the prescription. If a PA is prescribing inappropriately, his or her signature on the form may make it easier for a regulatory agency to identify the problem. As Lopes put it, "It provides a paper trail." ■

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EDITORIAL

Two rights rout a wrong – finally

If a law is passed and the people whom it was designed to benefit don't know about it, does it do them any good? This year, ISMS demonstrated to lawmakers that, in at least one case, the answer is no. Fortunately for women throughout Illinois, that demonstration produced action – a new law that ensures they will be told about the rights provided them by the original one.

The original law is the one ISMS prompted in 1996, allowing women covered by managed care plans access to a "woman's principal health care provider" (defined as a physician licensed to practice medicine in all its branches specializing in obstetrics, gynecology or family practice) without the hassle of obtaining a referral.

Most women consider the physician who provides their Ob/Gyn care to be their primary care physician, and see that doctor more frequently than they do any other. Physicians recognized that any referral requirement at best created more red tape and at worst caused unwarranted suffering by delaying needed care.

But even with this law on the books, women found difficulty getting to their principal care providers. Managed care plans, bitterly opposed to the law in the first place, too often decided to flat-out ignore it. One

woman reported that it took 12 phone calls and a letter to the Illinois Department of Insurance before her plan allowed her to exercise her right under the law. She said her plan refused to provide a list of qualifying physicians under contract to the plan. Worse, many plan staffers seemed unaware the law even existed.

Legislators realized that if the plan's staff didn't know about the law, then the plans could not possibly be doing an adequate job telling patients about it. So this year the General Assembly, with ISMS support, passed HB 3427 and sent it to the governor.

This new bill requires managed care plans to notify and clearly explain to every covered woman her right to choose a principal health care provider, as well as tell her how to get a list of the providers available under her plan.

Other parts of HB 3427 assure coverage related to cancer screening and diabetes management. The necessity of this bill illustrates the interference managed care plans are willing to impose on patient-physician relationships; it demonstrates the need for a comprehensive law like the ISMS Managed Care Patient Rights Act. Comprehensive reform will assure all managed care patients have access to the physicians they need when they need them.

PRESIDENT'S LETTER

Named HIV reporting remains sound public health practice

Richard A. Geline, MD



Health professionals must share information with those who are involved in the patient's care.

HIV/AIDS remains the top public health issue in the United States and, most likely, the world. Debate continues to emerge in the public health forum. The question locally is whether the Illinois Department of Public Health should require that names of HIV-positive individuals be reported to the state via local health authorities.

We have some encouraging news in the fight against this disease. New treatments that include fresh combinations of medications now markedly prolong the lives of HIV-positive individuals. Today, HIV and AIDS almost qualify as chronic diseases rather than universally fatal short- and medium-term conditions. According to figures from the Centers for Disease Control and Prevention, the national AIDS death rate diminished by 21 percent in 1996 and another 44 percent in the first half of 1997. Nonetheless, the rate of new infections has held constant.

Accordingly, IDPH has proposed amendments to the state's sexually transmittable disease code, and AIDS-confidentiality and -testing code. Right now, the state requires the reporting of such information about HIV-positive individuals as: city in which they live, age, race, gender, laboratory findings, risk factors, evidence of prior testing and if counseling and/or sex-partner referral is taking place.

Actual identification is now reserved for when the patient is diagnosed with full-blown AIDS. The proposed amendments would expand naming to include HIV-positive individuals. Opposition to the proposals developed almost immediately. At a recent public hearing held in late April, opposing testimony came from several sources, including the AIDS Foundation of Chicago, some community workers, some physicians and even some members of the Illinois General Assembly. Arguments advanced against the amendments included the fear of adverse consequences to the patient such as lost employment and insurance coverage. Opponents described named

reporting as a breach of traditional confidentiality and a rupture in the patient-physician bond of trust. Finally, opponents said, the proposals would decrease individuals' motivation to test.

ISMS' policy on the matter is quite clear: Health professionals must share information, including the patient's name, with those who are involved in the patient's care. The basis for this policy is simple. HIV infection should be considered an infectious disease and approached like many other infectious diseases. Named reporting is already required for 60 different infections, including tuberculosis, syphilis and gonorrhea. Adding HIV to the list is a simple expansion of public health practices that already exist.

Moreover, public health practice requires individual identification. Without access to the individuals involved, contact-tracing and necessary education cannot take place. We must remember that prevention remains the only certain way to limit this epidemic.

Further, the experience does not bear out the claim that required name reporting would discourage people from testing. A recent survey found that just over 1 percent of all patients had delayed testing because of reporting systems in their states.

Thirty-one other states mandate some form of name reporting. In these states, there has been no decrease in testing due to these laws. Regarding the issue of confidentiality, the IDPH has been collecting names of individuals with AIDS since 1981. IDPH's record in protecting confidentiality is unblemished, and we should anticipate that this standard of excellence will continue.

Because of the amount of opposing testimony, the proposed regulations have taken more time than expected to be approved. IDPH plans to conduct further studies and gather more information. ISMS believes the proposed amendments represent sound public policy and sound public health practice. We can only hope that the process will continue, enabling a continued fight against an epidemic.

LETTERS

Thanks, gratitude for Society guidance, support

On May 3, Sandy Drewes, MD, succeeded me as president of the Illinois Society of Anesthesiologists. We have been busy this year because of proposed advanced practice nurse legislation. Although most of the legislation was designed to allow collaborative arrangements with physicians to extend primary care practice, the nurse anesthetists used this opening to try to establish independent practice for themselves.

I want to thank the Illinois State Medical Society for its help with this issue. The encouragement and involvement of ISMS have been important. As you probably know, the overwhelming majority of the ISA membership also belongs to ISMS. As such, we have depended upon the resources and wisdom of ISMS to guide our efforts with the state legislature.

We have been particularly impressed with your legislative staff. They have been insightful, responsive and patient with us as we have dealt with these issues. ISA has increased its political awareness dramatically this year, but we realize that we would be much less effective without the guidance and support of ISMS. We also understand the need for our members to be active in ISMS itself.

On a related note, I want to thank the ISMS Division of Specialty Societies for its continued help with our annual meeting.

Again, thank you for the support of ISMS. It has made a difficult year manageable and rewarding.

Steven Hall, MD
Immediate past president
Illinois Society of Anesthesiologists

Breaking the ISMS, AMA link is only fair

We should definitely break the linked membership between ISMS and the AMA. We should have a choice of belonging to the society that serves our needs the best.

My own needs are best met by ISMS and the American College of Surgeons. I have never used any services of the AMA

and yet have been forced to pay thousands of dollars in dues.

As a surgeon, my income is half of what it was 15 years ago. I need to cut my expenses and I can save about \$700 a year if I have this choice.

I think we should have a vote from all members on this topic. That is the only fair way of deciding this issue.

Shafiq Ahmed, MD
Orland Park



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REPORT for Illinois Physicians

MEDICARE

MEDICARE PART B COVERAGE OF CONSULTATIONS (CPT® CODES 99241-99275)

Consultation Versus Visit: A consultation is covered when all of the criteria for the use of a consultation code are met. In general, a consultation is distinguished from a visit because it is done at the request of a referring physician (unless it is a patient-generated confirmatory consultation) and the consultant prepares a report of his/her findings, which is provided to the referring physician for the referring physician's use in treatment of the patient. A consultant may initiate diagnostic and/or therapeutic services. However, when the referring physician transfers the responsibility for treatment to the receiving physician at the time of referral in writing or verbally (i.e., following the request to evaluate and treat), the receiving physician should not continue to bill a consultation visit. He or she would bill a subsequent hospital care code in the hospital setting or an appropriate established patient code in the office setting.

Consultation Followed By Treatment: A consultation is covered if the referring physician does not transfer the responsibility for the patient's care to the receiving physician until after the consultation is completed.

Consultation Requested by a Member of the Same Group Practice: A consultation is covered if one physician in a group practice requests a consultation from another physician in the same group practice as long as all of the requirements for use of the CPT consultation codes are met.

Documentation of the Consultation: A request for a consultation from the attending physician and the need for consultation must be documented in the patient's medical record. A written report must be furnished to the requesting physician for his/her use in treating the patient.

In an inpatient setting, the request for a consultation may be documented as part of a plan written in the requesting physician's progress note, as an order in a hospital record, or as a specific written entry.

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Issue: 06/26/98 - DEB

Health Care Service Corporation, a Mutual Legal Reserve Company
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Quotables

An eye opener

"If you're faced with a primary angle closure and don't remember what to do in which order, don't panic. Just give the patient one drop of everything in your office that doesn't have a red cap, and give it often until the pressure comes down! While this is not the most scientific approach, it does have some merit - practically every topical medication in an optometric office except the cycloplegics/mydriatics will either help or do no harm, unless your diagnosis is incorrect."

- From "The Handbook of Ocular Disease Management," in February 1998 issue of Review of Optometry, second edition.

See a quote in a periodical you think is outrageous? Send it along with your name and telephone number and the issue name and date, to the Editor, Illinois Medicine, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602, or fax it to (312) 782-2023.

Coming soon:
Sexual
harassment and
other personnel
issues

ISMIE Update

Forecast remains stormy as PIE victims run for coverage

BY LINDA MAE CARLSTONE

[CLEVELAND] The Ohio Department of Insurance held a garage sale of sorts earlier this month, hawking used office furniture, secondhand artwork and recycled exercise machines to raise cash to fund debts related to the recent collapse of PIE Mutual Insurance Co.

The fund-raiser was one piece of a liquidation process the department is undertaking to corral assets of the Cleveland-based malpractice insurer that went belly-up earlier this year, according to ODI spokesperson Terri Leist.

All outstanding PIE policies were canceled on April 22, leaving about 15,000 physicians without coverage. Physicians scrambled to find replacement coverage, in some cases being forced to rebuy insurance when they had already paid premiums of \$100,000, Leist said. By law, they can recoup \$10,000 at best.

At the time it went under amid charges of financial mismanagement, PIE insured one in three Ohio physicians, according to Herb Gillen, a senior director of the Ohio State Medical Association.

Retired physicians were hit particularly hard because they are not even working, and they need to replace tail coverage for suits that could be filed from prior services, Gillen said. "I have talked to retired obstetricians who have paid as much as \$35,000 to \$40,000 for coverage on possible suits related to babies they took care of years ago," he said. "They don't want to go to sleep at night worrying that someone injured 10 years ago will sue."

Clearly, there are victims on both sides, Leist said. "There are people with legitimate claims, and the most they can get from a company in liquidation is \$300,000." Although it has not happened yet, many physicians are worried that their personal assets could be tapped to pay claims. The Ohio Insurance Guaranty Association, an

organization that moves into action when insurance companies are liquidated, will distribute the company's assets and negotiate settlements between policyholders and claimants. "The association will do its best to protect personal assets," Leist said.

The PIE ordeal has left observers pondering what, if any, warning signs went unrecognized by those monitoring the insurance industry. One red flag, said some experts, was the company's proclivity to finagle a market foothold by low-balling premiums. "You can only do that for so long," said Kimberly Wills, a vice president for insurance broker Aon Healthcare Alliance.

Gillen has also questioned why the insurance departments in each of the nine states in which PIE conducted business failed to warn policyholders.

The Ohio medical association itself has egg on its face

because of an endorsement relationship with PIE that lasted from 1994 until the 1997 collapse. In return for financial remuneration, OSMA allowed the company to use its logo and refer to the endorsement in its marketing materials.

The Ohio insurance department has been criticized as well for failing to forecast doom. The department has proposed state legislation that's now under consideration regarding the make-up of insurance company boards. The proposal seeks to prevent biases that tainted the PIE board, Leist said. "There was no one on the inside to ask the tough questions."

Unfortunately, no law or guideline can totally protect consumers if a company chooses to file false financial statements, Leist said. "You can't regulate those who choose to deceive." ■



Janet Atkinson/SIS

Caveat emptor: Look beyond cost to quality

The age-old adage that consumers who shop only by price will eventually get what they pay for has a shiny new example in the collapse of the PIE Mutual Insurance Co., once the nation's third largest medical malpractice carrier.

Insurance experts are sounding new cost-first cautions in light of the downfall of the Cleveland-based company, which often undercut its competitors' prices.

ISMIE has long been dogged by companies offering cheaper rates to gain a foothold in the market, explained Harold Jensen, MD, chairman of the ISMIE Board of Governors. The PIE saga "underlines in bold writing that there are repercussions for undercutting, for not pricing realistically," he said. "We at ISMIE have often wondered how long it would take for undercutting to have a negative outcome, but we never dreamed of a catastrophic result of this magnitude."

Stability, service, security and peace of mind must be weighed equally in the purchase equation, Dr. Jensen added. "ISMIE has a 22-year history of performance and fiscal conservatism. Those are the kinds of things you should look for in a malpractice insurer, just as you do in stocks and banking ... the kinds of things that have allowed ISMIE's industry ratings to continue to climb."

"Before buying malpractice insurance, physicians should discuss with their insurance agents and brokers the pros and cons of companies they are considering," said Terri Leist, spokesperson for the Ohio Department of Insurance, which is in the

process of liquidating PIE assets. "Look at more than price, ask about overall finances and company structure. Physicians should understand the policy and how settlements are made."

According to Kimberly Willis, a vice president for Aon Healthcare Alliance, an insurance brokerage firm specializing in professional liability coverage, there were warning signs PIE was in trouble. Prior to its collapse, PIE's financial ratings were sinking, which should have been a tipoff to consumers. Willis advised physicians to research ratings before buying.

The most frequently cited rating for carriers is A.M. Best, whose reports are available through brokers, as well as at most large public or university libraries. A few dollars saved in premiums can easily come back to haunt a physician, Willis stated.

Additional elements that should be considered when purchasing a plan include:

- How willing is the carrier to pay claims?
- How long has the carrier been writing physician malpractice coverage? Will it continue in the long term?
- What does the policy cover?
- Who does the policy cover? Does coverage include the physician, corporation and employees?
- What and who does the policy exclude?

Dr. Jensen also stressed the role of reliability and credibility in selecting a carrier. "Integrity should extend beyond a company's PR," he said. "It has to have some basis in fact – and it must be built into everything an organization does."

"How can you keep them down on the farm...?"

Joint ISMS, farmers' program turns 50.

By Jane Zentmyer

More than 50 years ago, World War II had come to an end, and the country had begun to focus its attention on problems festering at home while its soldiers were abroad. Here in Illinois, farmers and physicians finally had time to address a perennial problem: the shortage of physicians in rural areas.

Their solution? Turn "farm boys" into "country doctors."

That was the idea of Danville urologist Harlan English, MD, and others who founded the Rural Illinois Medical Student Assistance Program in 1948. As chairman of the ISMS Committee on Rural Medical Service, Dr. English led the joint effort between ISMS and the Illinois Agricultural Association (better known as the Illinois Farm Bureau) to get the loan program off the ground.

He summarized the program's challenge colorfully – albeit with politically incorrect language by today's standards – in a 1954 Medical Economics article: "We knew there was no shortage of farm boys studying medicine. The trouble was, they weren't carting their knowledge back to the farm. They were marrying blondes in Chicago and staying there. As a result, we've got a thousand doctors too many in Chicago and not nearly enough in the country."

"But don't misunderstand me. You can't just transplant big-city doctors. They wouldn't know what the farm people were talking about."

So RIMSAP's goal was not only to give students a medical education, but also to encourage them to practice and settle down in a rural town once they completed their training. That goal still pervades the program today.

"We have a high regard for metropolitan areas, but we're looking for those who will serve the rural populace," said Randall Mullin, MD, chairman of the RIMSAP board and a recipient of the program's benefits. "And we're looking for specialties within medicine that will serve that end."

The program assists Illinois students interested in primary care fields such as family practice, general surgery, internal medicine, pediatrics and Ob/Gyn. A board with three physicians and three farmers interviews students interested in a medical career to determine their drive, ambition and commitment to serve a rural area.

Students who get RIMSAP's recommendation stand to reap two benefits – assistance in getting accepted to medical school and help paying for their education. In exchange, they promise to practice in a primary care field for a minimum of five years in a rural town.

Then

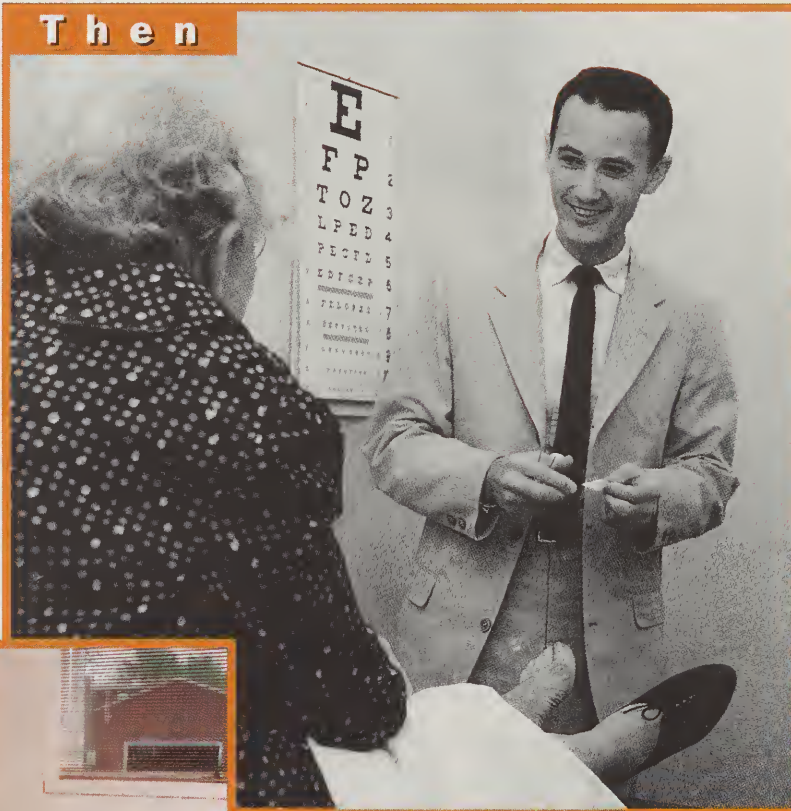
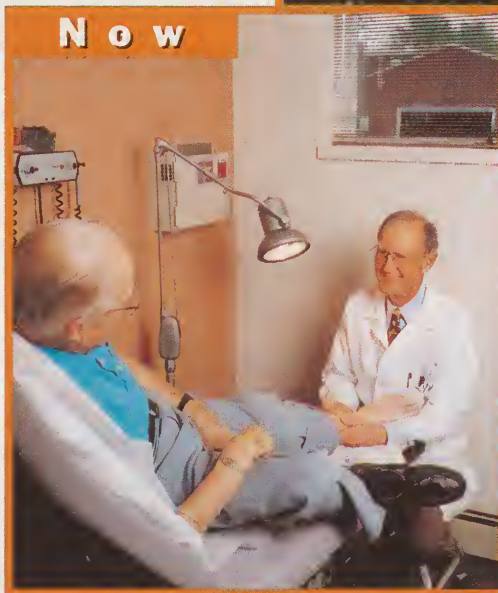


Photo courtesy of Dr. Gibbs

Now



Duane Zehr

Then and now: In a photo from 1959 (above), surgeon Jack Gibbs, MD, a RIMSAP graduate, meets with a patient in his rural office. Today, Dr. Gibbs practices in rural Canton, where he recently struck a familiar pose (left) with Canton resident Leon Chevillon.

A state law passed more than 50 years ago helped jump-start the program. It requires the University of Illinois College of Medicine to set aside a certain percentage of open slots for applicants recommended by RIMSAP. Qualified students may get a

better shot at attending medical school if their application carries a RIMSAP recommendation.

When the program started, ISMS and the Farm Bureau contributed seed money that allowed RIMSAP to offer low-interest loans to students; today, the program is self-sustaining. Students are eligible for loans up to \$2,500 per semester, for a total of \$20,000 during medical school. Interest on the loans is 4 percent, and repayment of the principal begins three years after the end of postgraduate medical training. If students fail to live up to their five-year commitment, the loan must be repaid immediately in full, with a penalty added to it.

Jack Gibbs, MD, became a RIMSAP participant during its first years. He hoped to be a family physician, but needed a loan to finance his education. One of the program's co-founders, E.P. Coleman, MD, told

(Continued on page 8)

On the farm

(Continued from page 7)

him about RIMSAP, which "was in sync with what I was planning to do anyway." He has spent his career practicing in a rural area. Even today, he practices in Canton, southwest of Peoria.

Several years into his practice, Dr. Coleman recruited Dr. Gibbs to serve on the RIMSAP board. "I had seen the problems that developed as a result of manpower maldistribution for Downstate communities, and wanted to see the program thrive and flourish," said Dr. Gibbs, who spent more than 25 years as RIMSAP's board chairman. "It's done great. Things are probably better as a result of our program, which has attracted many physicians throughout the Downstate area."

In 50 years, over 600 RIMSAP physicians have graduated from medical school and practiced in a rural area for at least five years. (Another 200 are currently in school or residency.) At least 400 physicians have chosen to remain in small towns beyond their mandatory five years.

Take Stacy McConkey, MD, for example. She finished her residency in 1997 and, in keeping with her commitment to RIMSAP, returned to her hometown of Geneseo to become its only pediatrician. "Business is slowly picking up," said Dr. McConkey, who works at Genesis Medical Group. "It takes a little time. They've never had a pediatrician here before."

Dr. McConkey always knew she was interested in a primary care field and was attracted to RIMSAP because of the "kick in the door" she'd get with her medical school application and the low-interest loans. "I think it's a great

way to get into medical school, and it's a wonderful way to get physicians into small towns."

After 50 years of effort, RIMSAP has earned the appreciation of many. The Illinois General Assembly congratulated ISMS and IAA for continuing "to address the medical manpower needs of rural Illinois through this program, which begins its second half-century in 1999." A resolution from the ISMS House of Delegates "commends [RIMSAP] on achieving its 50th year of service to the citizens of Illinois, medical students and the medical profession."

"Generally, if you start something like this and it lasts ten, fifteen or twenty years, you've done pretty well," said Bill Klein, a farmer from the south-central Illinois town of Flora, who sits on the RIMSAP board. "The fact that it's been able to continue for so many years is really remarkable." ■



Stacy McConkey, MD, of Geneseo, tends to 9-month-old Atkinson resident Emma Vandemore.

Duane Zehr

There's always

(Continued from page 1)

prescription or order a test," Dr. Varney said. "It may just be going to the bedside and being a friend."

Too often, physicians don't take the time to learn patients' wishes on such matters as life-sustaining treatments, said Dr. Varney, a member of the Illinois Senate Task Force on Comfort Care for the Terminally Ill currently studying measures to improve care for the dying.

He pointed to a study in the Nov. 22/29, 1995, issue of the Journal of the American Medical Association that confirmed shortcomings in care for seriously ill, hospitalized adults. Only 41 percent of the patients in the study reported talking to their physician about prognosis or cardiopulmonary resuscitation. About 50 percent of patients wanting CPR withheld had no written do-not-resuscitate order.

Dr. Varney blames the communication lapse in part on a culture that shuns talking about mortality issues. Physicians cited several reasons for this lack: They don't have enough time, they feel uncomfortable bringing it up, they don't want to destroy a patient's hope.

The paper part of the advance-planning equation emphasizes documenting patients' wishes.

Everyone — young and old, sick and well — should provide written advance directives to their physicians, said Deanna Mool, chief counsel for the Illinois Department

of Public Health, who added that physicians also need to document their discussions about care in patients' charts. "We see situations where nursing homes fax a DNR order to a physician to sign," she said. "But it is not clear if the patient was consulted. From a malpractice standpoint, failure to document who the physician consulted, and why, can end up in a wrongful death suit."

The department also sees cases in which physicians consult someone other than the designated power of attorney, with no explanation in the chart. Mool maintained that although physicians are allowed to take direction from someone else if the power of attorney is unavailable, they should document why they did that.

Physicians should exercise good timing when they encourage patients to fill out advance directive documents. "The best time to discuss dying is when a patient is not," Dr. Varney said. "When they are well and have a clear head."

Dr. Varney admits that bringing up the subject of death can be touchy. "You have to know what you can bring up without scaring them."

Dr. Varney added that there is a need for improved CME education focusing on physicians' death and dying awareness. "Not all physicians possess the skills to lead a patient down that path," he said. "But you're a better doctor if you do. It's the difference between being a technician and being a physician."

Planning for death

(Continued from page 1)

health care decisions.

Another change in the law included in the new brochure is the Mental Health Treatment Preference Declaration, an advance directive addressing mental

health decisions. The declaration lets patients indicate if they would want to receive electroconvulsive treatment, psychotropic medicine, or admission to a mental health facility. The booklet informs patients that they can write their own wishes in advance or select someone to make mental health decisions for them.

The brochure is developed under the auspices of ISMS, which also prints and distributes it. It includes three statutory forms that can be filled out to designate a living will, power of attorney for health care and declaration for mental health treatment.

Additionally, the process for organ donation is explained in the brochure, and an organ-donor card is included.

The publication puts potential donors' minds at ease about issues that may make them hesitant to participate. It points out that donations take place only after everything has been done to save the donor's life, that the procedure is surgical, professional and dignified, and that it does not interfere with traditional funeral and burial customs. It also notes there is no cost to the donor's family.

The Society fills about 200,000 requests a year for the brochure. It can be purchased for 40 cents each for up to 1,000 copies, with graduated price breaks for quantities over 1,000. ISMS members can receive up to 300 free copies per year; single copies are available to the general public at no cost. To order, call 312-782-ISMS, ext. 1221. ■

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Visiting the front lines

(Continued from page 1)

a physician.

The intern – whether an attorney, a health-insurance purchaser, a legislator or a labor official – shadows his or her chosen physician for a day. They often find themselves on health care's front lines with an eye-opening opportunity to learn about the intrusions and hassles a physician faces every day.

Green said that was one of the strongest impressions he had as the result of his work. "I think physicians and hospitals must have more money

so they can provide more [care] for our people in there. The costs keep going up for medical professionals because there are so many things they have to do before the operation. All the assistants, all the techs – those people all work for somebody, and that cost goes right back to the doctors."

Wheaton Mayor James Carr shadowed four physicians in DuPage County during a two-day mini-internship stint. Like Green, he found medicine to be fascinating.

"But what I got out of it most was seeing how physicians reach out to

patients. They have a high level of training and experience, but they relate so closely to patients on a personal level," Carr said. After his time with Bart Green, MD, geneticist Robert Lebel, MD, otolaryngologist James Lee, MD, and emergency medicine physician Susan Nedza, MD, Carr said he felt like a resident himself.

Melissa Marsden, a communications staff member at Rockford's Sundstrand Corp., interned with physiatrist Peter Park, MD, a specialist in physical medicine. She said she saw parallels between the work of physicians and her employer, Sundstrand, a govern-

ment contractor that makes parts for the aerospace industry. "We're quite used to dealing with an enormous amount of red tape. Our folks realize there's got to be a way to simplify things," she said.

Marsden said she learned about the industrial-rehabilitation services offered at Rockford Memorial Hospital, services that have been used by several Sundstrand employees. "When people have workplace injuries and are recuperating, and are almost ready to go back on the job, they go to Rockford Memorial where they have sites set up to simulate the work environment," Marsden said.

Some of the interns who took part in the program had medical experience

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themselves. For instance, Sen. Frank Watson (R-Carlisle) runs a pharmacy that has been in his family for more than 100 years. "I'm a pharmacist, but I'd never really been in an operating room before," said Watson, who interned with Belleville general surgeon Tim Bradley, MD. He said that he and Dr. Bradley saw about 20 patients that day. The highlight for Watson was observing Dr. Bradley perform surgery on a patient with a dislocated finger and a severed tendon, the results of a baseball injury.

An Illinois lawmaker since 1972, Watson has been intimately involved with health care issues, serving on the Licensed Activities Subcommittee in the Illinois House from 1978 until 1982, and on the Public Health Committee in the Senate from 1982 until 1992. That tenure gave him some insight into what managed care has done to the practice of medicine in Illinois.

Watson said his mini-internship reinforced many of his concerns about the effect of managed care on the health care environment. Some managed care programs, Watson said, force the burden of paying for benefits onto payors not under capitation.

Another legislator, Sen. George Shadid (D-Pekin), interned with Peoria internist Thomas Kouri, MD, his personal physician. Like other interns in the 1998 Alliance program, Shadid said he was a little hesitant when it actually came to going into a hospital room with the physician. "I felt the patients wanted privacy, not a politician sitting in," Shadid said.

Shadid, a former sheriff who doesn't currently sit on any health care-related committees, said he understands some of the changes that physicians now face, partly as a result of what he saw during his mini-internship. "Years ago, doctors were more independent. Now, they're like employees," Shadid said. "But doctors should determine whether you stay in a hospital or are released." ■

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Insuring the "uninsurable"

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Illinois Medicine

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Soaking up CME

PAGE 8



"CASE CLOSED." The AMA's new chief executive E. Radcliffe "Andy" Anderson, Jr., MD, said at the annual meeting the Sunbeam incident should be laid to rest. "As far as I'm concerned, this case is closed. We're headed in the right direction - leading this association toward what's new and important and necessary."

Sundown for Sunbeam?

MOVING FORWARD: AMA annual meeting seeks to shift limelight onto future.

BY LINDA MAE CARLSTONE

[CHICAGO] All told, the American Medical Association considered 107 reports and 334 resolutions at its annual meeting last month in Chicago, but it was the name of one appliance company that, prior to the meeting, threatened to steal the show.

Instead, however, the AMA House of Delegates acted to give the controversial failed marketing strategy a final curtain call.

Delegates adopted a report by the Ad Hoc Committee to Study the Sunbeam Matter finding the AMA Board of Trustees had no knowledge of the Sunbeam endorsement deal prior to its public announcement. The report included several recommendations to ensure that a situation similar to Sunbeam is not repeated in the future, including a rededication to professionalism, better training, and clarification of both the board's responsibilities and the executive committee's duties.

The move-beyond-Sunbeam theme was reiterated by AMA

leaders, including new chief executive E. Radcliffe "Andy" Anderson, Jr., MD. "The case is closed," Dr. Anderson stated in his first formal remarks to the House of Delegates on June 14, the meeting's opening day. Lynn Jensen, the AMA's chief operating officer and, for the past six months, interim executive vice president, said that the association has moved on with the business of the AMA, with an

agenda stressing vision, membership and unity.

"The AMA House spoke and the sentiment was to put the matter to rest," said ISMS president Richard Geline, MD, a member of the Illinois delegation. Now its time for Illinois physicians to think about what the AMA decided and draw their own conclusions, he said.

As a result of an ISMS resolution
(Continued on page 10)

E&M debate takes a new twist

CONFLICT: AMA House adopts new policy; HCFA immediately calls it unworkable. BY JANE ZENTMYER

[CHICAGO] The "bullet point" or "cookbook" approach to medicine should be eliminated from a revised version of the 1997 E&M documentation guidelines and not be included in future versions, the American Medical Association's House of Delegates decided at its June annual meeting.

Don't count on it, replied the U.S. Health Care Financing Administration. "The resolution would essentially nullify the guidelines without providing any viable alternative," said Robert Berenson, MD, director of HCFA's Center for Health Plans and Providers, a medicare division.

The 1997 E&M guidelines are currently delayed indefinitely. Physicians can use either the 1997 or 1995 versions to document their work. The announcement of the delay was made at an April AMA fly-in, bringing together more than 300 physicians and others to create new, simplified guidelines.

However, this new documentation framework placed a high priority on quantification - the

checklist-type approach that attracted the ire of the AMA House. The resolution it adopted incorporated points from several state societies, including ISMS, and stated the AMA must "oppose any documentation system that requires quantitative formulas or assigns numeric values to elements in the medical record to qualify as clinically appropriate medical record-keeping."

(Continued on page 13)

Physicians lobby for federal rights bill

ORGANIZED MEDICINE: AMA and ISMS want strong legislation making health plans accountable for their decisions; D.C. fly-in planned. BY JANE ZENTMYER

[CHICAGO] With dueling federal patient rights plans before Congress, the American Medical Association has organized a national effort to get physicians talking to their representatives and senators about the need for meaningful federal managed care reforms.

ISMS has taken up the legislative cause in Illinois. During Congress' summer recess, physician leaders met with Illinois Republican representatives to state the case for reforms, such as holding self-insured health plans liable for their medical decisions.

At press time, ISMS physicians were also scheduled to participate in an AMA fly-in scheduled for July 21. On this

day, physicians from across the country were expected to converge on Washington, D.C. to lobby Congress about the

importance of a broad patient bill of rights. (Watch the next issue of Illinois Medicine for

(Continued on page 14)

Poison pill could choke patients' rights

Too much of a good thing, politically speaking, can choke the life out of good legislation. That's the fear among representatives from the American Medical Association and ISMS as they press for passage of a federal patient bill of rights during the final days of this Congressional session.

Including tort reform in Washington's current managed care legislation, however, would be like feeding it a "poison pill." That's the message organized medicine delivered to Congressional leaders this month.

While physicians support caps on medical malpractice awards, the concern is that mixing them with a patients rights bill will assure the bill's demise either in the Senate or by means of a presidential veto because tort reform does not have

(Continued on page 14)

INSIDE

Urologists
settle with
FTC

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Urologists, feds settle price-fixing dispute

[PARK RIDGE] While some might say Chicago-area urologists blinked in the face of the price-fixing accusations leveled at them by the Federal Trade Commission, their struggles served to spotlight an issue increasingly vital to a growing number of Illinois physicians — those with ownership interests in medical services firms.

Earlier this year, more than 100 physicians — nearly half of all urologists in the Chicago area — deferred to the federal government, agreeing to change the way prices are set for lithotripsy, the nonsurgical destruction of kidney stones using sound waves.

At issue in the FTC suit was whether the doctor-owners of Parkside Kidney Stone Centers, a Park Ridge firm providing lithotripsy at sites in Park Ridge and LaGrange, could set a single price for physician services. Since 1985, when the company was originally formed, the physicians had been doing just that, with prices rising over the years from around \$2,000 to more than \$10,000 today.

Physicians claimed prices were set at the request of insurance companies needing a better understanding of costs related to the emerging technology, and customers' desire for streamlined pricing. The FTC, however, took another view.

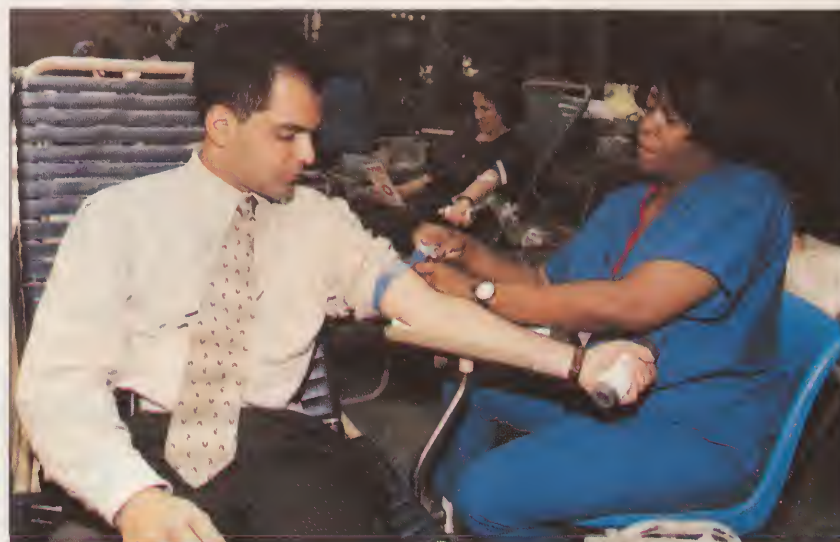
According to the FTC, the urologists maintained separate and competing medical practices, and, as such, were forbidden by the Sherman Antitrust Act

from creating a set price for their services. "The price-fixing agreements restrained competition both among the urologists who are owners of the Parkside venture, and among nonowner urologists who used the Parkside facilities, resulting in higher prices," an FTC release stated.

Julie Grego, Parkside's executive vice president, responded to the settlement by saying that the firm has long been in total compliance with the agreement. She added that "it has been a challenge to balance changing requirements of insurers and third-party payers with the continually evolving FTC rules. As soon as we knew of the FTC concern, we adjusted our practices. We are pleased that we have now established systems which satisfy the FTC, and that we can put this behind us."

Richard Raskin, an attorney with Chicago's Sidley & Austin, who represented the Parkside physicians, said his clients admitted no guilt and suffered no detrimental professional impact from sparring with the FTC. However, he added, they should stand as an object lesson to other physicians who might be involved in joint ventures founded on new medical techniques.

"When they opened Parkside, lithotripsy was not generally accepted," he said. "But the results were so phenomenal, it helped so many people, the centers just took off." The FTC complaint, he asserted, was the result.



John McNulty

Blood drive draws caring donors, exceeds goal

The timing was right for the June 13 ISMS-Medical Student Section Blood Drive, held in conjunction with the American Medical Association-MSS annual meeting in Chicago. With the reserve blood supply in Chicago suffering a critical shortage, the event — at which 57 units were collected — far exceeded the group's 40-unit goal. ISMS-MSS Chairman Harsh Sulé (left), of the University of Illinois at Chicago College of Medicine, was one of nearly 70 people rolling up their sleeves to part with a potentially lifesaving pint. Donor specialists like Eula Williams (right) joined Sulé and Margit Lister (background), a student at Wright State University School of Medicine in Ohio, in the community service project. A highlight of the annual meeting was the election of ISMS-MSS Secretary Sanjay Saxena of Northwestern University Medical School as Speaker of the AMA-MSS.

"Managed care contracted pricing is a sensitive area," said Raskin, who advised that independent physicians who come together be careful. "They need to direct

their full attention to details," he said. "The FTC and the Justice Department are very interested in pricing when physicians come together in a venture." ■

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State plan insures "uninsurable" Illinoisans

COVERAGE: CHIP offerings benefit patient-physician relationship. BY JANE ZENTMYER

[SPRINGFIELD] Patients struggling with serious medical conditions should be worrying about their health – not their health insurance. But once private insurers label them as uninsurable, what can these patients do to continue coverage? The answer: Contact the Illinois Comprehensive Health Insurance Plan.

"If someone has been turned down for health insurance coverage, or if they have changed jobs or are thinking of changing jobs and fear losing health insurance coverage, they should give us a call," said Richard Carlson, CHIP's executive director. "We may be able to help."

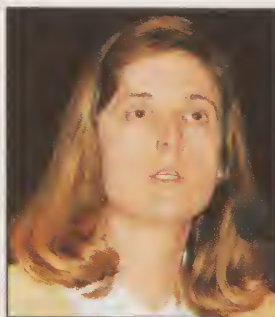
CHIP, a state-run program launched in 1989, makes health benefits accessible

to Illinois citizens deemed uninsurable because of current or previous medical conditions. To spread the word about the program, Gov. Jim Edgar set a public information campaign in motion by declaring July "CHIP Awareness Month."

Physicians can participate in this process, said Janis Orlowski, MD, a CHIP board member and secretary-treasurer of the ISMS Board of Trustees. "If your patients are having trouble getting insurance – and they're not eligible for Public Aid – [encourage them to] call CHIP."

Patients may discover they're eligible for CHIP's newest insurance product, launched last year to implement the federal Health Insurance Portability and Accountability Act in the Illinois insurance market. During its first year, more than 1,200 Illinois citizens received health coverage from this program without a waiting period or exclusion for pre-existing conditions.

People who apply for coverage in the individual market have usually left a job with group coverage to become self-employed, taken early retirement or been laid off. CHIP guarantees coverage to all "federally eligible" Illinoisans seeking



Dr. Orlowski

health insurance.

To become and remain federally eligible, Illinois residents must have no other group coverage or Medicare or Medicaid coverage and must first exhaust any COBRA coverage. They must also have accumulated at least 18 months of credible health insurance coverage without a 62-day break.

"These are very stringent federal regulations," Dr. Orlowski said. "Physicians should tell their patients not to wait [to apply to CHIP]." If they don't apply for coverage within 62 days after COBRA expires, they could lose their federally eligible status and their ability to buy CHIP insurance.

The state HIPAA plan is funded by an assessment levied against the state's insurance companies, Carlson said. In fiscal 1998, the state collected \$7.5 million, more than the program needed.

Illinois' chosen method of implementing HIPAA has become a national model. Other states enacted HIPAA by requiring all private insurers to cover high-risk individuals. However, the federal General Accounting Office found several problems with this approach, including the exorbitant rates

insurers charged these individuals for insurance.

The premiums for the HIPAA rates are set in the statute, Carlson said. For now, the premiums average about \$330 per person per month, approximately 135 percent of the rates in the private market.

The HIPAA plan isn't the only one available to patients having trouble finding insurance. CHIP's traditional product, which has been available for nine years, offers insurance to people who can afford it, but who are rejected by private companies because of a medical condition. During the past nine years, more than 15,000 Illinoisans have received coverage through this option, with over \$265 million in paid benefits.

The state's annual CHIP appropriation dictates the number of people who can receive benefits, Carlson said. Dr. Orlowski added that CHIP monitors its costs carefully to maximize the number of people it can cover. Premiums charged to enrollees are similar to the HIPAA plan.

The CHIP board places a high priority on the patient-physician relationship, Dr. Orlowski affirmed. "Every time we look at changes in the program, we try to look first at the patient-physician relationship and make sure these people – who have chronic illnesses and huge medical charts – are able to stay with a familiar physician who knows them well."

CHIP can be reached toll-free at (800) 367-6410. More information is found on its Web site: www.state.il.us/ins/chip.htm. ■

AIDS deaths drop; experts voice optimism, concern

[CHICAGO] Health officials expressed guarded optimism in the wake of a marked drop in Chicago AIDS deaths for 1997. While the decline says much about advances in treatments, medications and safer sex, experts acknowledged concern that it might diminish public attention on prevention.

Still, the drop in AIDS-related deaths in 1997 echoes national trends in AIDS mortality, which decreased with the use of antiretrovirals, prophylactic medications and protease inhibitors, said Steven Whitman, Ph.D., director of epidemiology at the Chicago Department of Public Health.

In Chicago, there were 377 AIDS-related deaths in 1997, less than half of the 783 deaths recorded in 1996, and the lowest death total since 1988.

The drop was consistent across racial and ethnic groups. Deaths among non-Hispanic blacks fell from 474 in 1996 to 258 in 1997. Deaths among non-Hispanic whites dropped from 196 to 73, and among Hispanics, deaths dropped from 104 to 45.

Especially significant was the fact that deaths among women fell for the first time, with 79 in 1997 down from 124 in 1996. Male deaths also fell from 659 in 1996 to 298 in 1997.

"Today's news on AIDS mortality is certainly welcome," stated Anne Meegan, CDPH interim Acting Commissioner for HIV/AIDS. "Yet it comes with a challenge. Significantly greater resources are needed to assure that everyone living with HIV has timely and complete access to medications and other health care." ■

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EDITORIAL

AMA acted – Did they do enough?

Earlier this year, ISMS sounded a warning to the American Medical Association that things were not quite right. The Society gave notice that a formalized process to reconsider the long-standing linked membership arrangement with the AMA would soon be underway.

The warning has given the AMA an opportunity to show by words and deeds that it can be the open, accountable organization Illinois physicians have demanded. The question remains: Have they succeeded?

At its annual meeting last month, the AMA House adopted an amended ISMS resolution calling for cost accounting of the fizzled contract with the Sunbeam Corp. The House also said yes to an ISMS resolution for the AMA to fully explain its relationship with the U.S. Health Care Financing Administration. And it referred to the AMA Board of Trustees for further consideration of an ISMS proposal that the AMA open all board, council, advisory committee and subcommittee meetings to members, as well as to representatives of various other organizations.

Now the platter is back on the ISMS table. It's time for members to digest the AMA's response. Has its offerings satisfied the physician appetite for improvement? Do members agree or disagree with the AMA's decision to put Sunbeam

to rest? Has the Association fought hard and well to protect your interests in the E&M coding debate?

As directed by the ISMS House of Delegates at its annual meeting in April, the ISMS speaker and vice-speaker are currently appointing a special committee to study the choice of Illinois becoming a deunified state. At its June meeting, the board authorized the speaker and vice-speaker to call a special ISMS House meeting deliberating the committee's findings if it concludes business prior to the 1999 dues billing cycle. If called, it will be the first special House meeting since 1975.

ISMS members were given a convenient means of expressing their voice; the Society recently sent a 64-question mail-in survey to all Illinois physicians in order to identify medical-practice issues and priorities. Several questions dealt directly with AMA performance and unification. For example: Has the AMA lost touch with the average practicing physician? Does the AMA do a good job representing physicians? Do you think Illinois should remain a unified state?

The survey was one way that each and every physician could register a vote on AMA. The answers are being tabulated and will be considered by the special deunification committee as it weighs this vital decision.

PRESIDENT'S LETTER

Physicians' contentious E&M stand one of principle

Richard A. Geline, MD



*The message ...
was clear:
Doctors want
action – now –
to stop the
bureaucratic
hassles.*

I didn't hear anyone actually say, "I'm mad as hell and I'm not going to take it anymore!" like Howard Beale in the movie "Network." But there was no mistaking the sentiment on the floor of the American Medical Association's annual meeting.

This year's House of Delegates displayed a militancy unlike any I had seen there before. The message expressed by your Illinois delegates and others was clear: Doctors want action – now – to stop the bureaucratic hassles and interference we face every day.

This lust for action was evident in the large number of resolutions filed (over 300 – the 3-inch packet weighed more than 10 pounds), and in the refusals to refer some complex, controversial reports back for further study. Perhaps it even showed in the House's acceptance of the special committee report on the Sunbeam affair, a move that could be read as a willingness to put that attention-diverting issue in the past.

Nowhere, though, was the attitude more evident than in the House's action on the federal government's roundly criticized E&M documentation guidelines.

AMA leadership might have come to the annual meeting expecting congratulations rather than contentiousness regarding E&M. Their April 27 "fly-in" meeting had given a forum to the concerns of over 300 physicians and other medical representatives from around the country. It announced that medicine had won an indefinite delay in the implementation of onerous regulations, as well as assurances from the U.S. Health Care Financing Administration's Office of the Inspector General that honest coding errors would not result in fraud and abuse prosecutions. Everyone promised to continue working together in order to simplify guidelines and ease regulatory burdens.

However, contentiousness is what AMA leadership found in June. The Board of Trustees' report detailing the AMA's work on E&M was met with 19 resolutions expressing physician discontent. Illinois' resolution summed up the concerns of the House rather

comprehensively. It called on the AMA to oppose implementation of the guidelines, make them voluntary and eliminate random auditing as an enforcement tool, and it urged development of guidelines reflecting quality medical care rather than an "audit checklist."

That last point fueled serious debate. No matter how much less intrusive the AMA's efforts may have made them, the E&M guidelines still amounted to an audit checklist. Echoing the Illinois House of Delegates, the AMA House stated forcefully that this wasn't good enough.

The House combined the board report and the 19 resolutions into a single resolution with three separate "resolved" statements supported by 19 subpoints. The final subpoint ordered the AMA to "oppose any documentation system that requires quantitative formulas or assigns numeric values to elements in the medical record to qualify as clinically appropriate medical record-keeping."

Illinois' message was heard. Rather than accept a bad deal with a sense that it could have been worse, grassroots physicians in the AMA House decided to stand on principle. The medical record is a clinical document, not an itemized bill.

This is not an inconsequential stand. AMA leaders have argued that the House's policy could push HCFA into developing E&M standards without physician input. Almost on cue, the July 6 issue of American Medical News reported that HCFA called the House policy "unworkable," and a top official from the agency threatened to implement guidelines "with or without AMA involvement."

While the House did commit the AMA to continued work with HCFA in order to develop appropriate guidelines, the delegates' action suggests doctors will not settle for an agreement for agreement's sake. The House's answer to the government's threats appears to be inspired by another line of film dialogue: "Go ahead. Make my day."

LETTERS

AMA a key player in E&M coding revamp

[The following was written prior to the AMA Annual Meeting.]

I believe the May 15 report in Illinois Medicine headlined "Medical Society drives rollback of E&M guidelines" unfairly casts the American Medical Association as the villain in the scenario. In fact, nothing can be farther from the truth.

Here is a brief background: The 1997 guidelines were developed over a three-year period by the AMA CPT Editorial Panel, working closely not only with the U.S. Health Care Financing Administration, but also with more than 90 advisors appointed by the national medical specialty societies. The goal was to refine the criteria in a particular area of the guidelines: single specialty and multi-system exams.

These revisions were needed to help those physicians in specialties focusing on a single organ system. Otherwise, those physicians would have been effectively and arbitrarily prohibited from reporting the type of more advanced patient care encounters typically coded as Level 4 & 5 visits.

HCFA issued the revised guidelines in April 1997, with an effective date of Jan. 1, 1998. Almost immediately, concerns were voiced that because of the greater detail required by the new guidelines, and the scope of the necessary educational requirements, the guidelines could not be brought on line that quickly. Further, the new guidelines proved extremely complex and burdensome.

The AMA expressed those concerns to HCFA in the fall of 1997, and HCFA in December responded by granting a grace period of six months, postponing the implementation date until July 1, 1998.

Our AMA House of Delegates

directed the AMA to address the concerns of practicing physicians. We held a series of meetings with HCFA to discuss effective solutions. We encouraged physicians to comment on the necessary and important changes they believed the guidelines required.

We scheduled the April 27 "fly-in" in Chicago, at which more than 300 leaders from all of organized medicine took part. Members of the AMA Board of Trustees, the CPT Editorial Panel and HCFA were available to hear specific problems and assist in developing solutions. Also on the table was a new framework for E&M documentation, along with alternate formats that may ease the guidelines' usage in some clinical situations.

It is not true that the E&M guideline problem was created solely by the AMA, which then did nothing to solve it. The truth is that many intelligent physicians from all ranks of the profession labored to produce a necessary set of guidelines. Unfortunately, that product turned out to be unworkable. When this became apparent, those same individuals and their organizations immediately began working toward a solution.

HCFA has made it clear that some type of E&M documentation will be put in place. However, during the April 27th fly-in, HCFA announced that it was instituting a grace period of indefinite time to allow for sufficient testing of the new version of the guidelines and to educate physicians and carrier review staff. The AMA has and will continue to work cooperatively with the Federation at all levels. I sincerely hope that future issues of Illinois Medicine will cover this issue in less one-sided terms.

Percy Wootton, MD
Past president, AMA

Bon voyage and thanks for the many memories

As I reflect upon (and count) my blessings over the past 31 years in organized medicine, I realize the experience has truly been a labor of love — especially the 12 years on the ISMS Board of Trustees. Serving ISMS and its member physicians has given me a rich, full life working with, and for, other people.

When we recognize and accept that we are all intricate parts of an organization, we learn to respect and love one another more deeply, and we get back from life an enduring peace, satisfaction and joy.

My opportunity to serve the ISMS, the zenith of organized medicine in Illinois, has provided an abundant life — full of many, many more pluses than minuses. The reason lies in the cooperation and support that I received from "the ISMS Family" — staff; county medical societies' staff and leadership; former and current members of the General Assembly; news media and our many friends of organized medicine in the communities of Illinois. In no other profession or occupation could I have met and worked with so

many wonderful people. I always looked forward to these relationships as an opportunity and challenge to help ISMS continue and flourish as a viable and progressive organization. All of my endeavors were designed to keep the physician and our patients as a direction for our work.

My thanks to the countless individuals who have been willing to serve and assist in maintaining ISMS as a national leader in organized medicine. It has been a privilege and honor to work with you, and I wish only the best for you and our medical society in the future.

As a physician leader of organized medicine with a very loyal and dedicated staff, it has been a most memorable 31-year cruise. Bon voyage.

George Wilkins Jr., MD
Edwardsville, Ill.

Editor's note: After longstanding service to organized medicine, including stints as ISMS president, chairman of the board and chairman of the IMPAC Council, Dr. Wilkins is enjoying retirement!



Your insurance company called to inform us that it does not consider giving birth a medically necessary procedure.

GUEST EDITORIAL

Tort reform is key to patient safety efforts

By Lawrence Smarr

Reprinted with permission of The Physician Insurer, the quarterly publication of PIAA.

The issue of patient safety has received significant and much-needed attention in recent years. Of course, Physician Insurers Association of America member companies pioneered the risk-management programs that established the foundation for most contemporary efforts. For this reason, physician-owned companies have always embraced patient-safety initiatives by other entities as a logical extension of their own work.

Much of the recent discussion concerning patient safety has focused on the idea of physicians freely admitting possible mistakes and unexpected outcomes to patients without fear of the consequences. Unfortunately, under the nation's current tort system, such admissions can hardly be made without significant risk to the physician.

The question arises then, if patient safety efforts are dependent on the free admission of errors by health care providers, can society really make significant strides in patient safety without first reforming the U.S. tort system?

There is no question that an atmosphere in which people feel free to openly admit and discuss medical errors would benefit all concerned, whether they be patients or doctors. The PIAA's member company in the Netherlands reports that such a system exists there.

Mistakes are much more readily admitted to in the Netherlands because the country has an extensive social safety net that makes arguing over things such as the costs of long-term care irrelevant. Instead of medical professionals having to huddle with lawyers to discuss their possible legal exposure in the wake of a medical accident, doctors can openly discuss problems and suggest solutions.

Recently the Joint Commission on Accreditation of Healthcare Organizations published a new sentinel-events policy. A sentinel event is any unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. The goal of the new policy

is to gain knowledge about medical errors and reduce their frequency in the future.

The JCAHO's goal was admirable. Almost immediately, however, the proposed changes ran into trouble. Respondents (including the PIAA) expressed concern about the potential for sentinel-event reports to be subject to the evidentiary discovery process. This could result in a situation in which practitioners may choose not to participate in root cause analyses to protect their own rights should a future legal action arise. Also, PIAA member companies warned that if sentinel-event information is discoverable or available to the public, it may result in an increase in the number of unwarranted lawsuits.

A recent article by Dr. Albert Wu of Johns Hopkins University called on medical professionals to freely admit their mistakes. This article received significant press attention, although most of the coverage omitted one important detail: one of Dr. Wu's key suggestions for encouraging the admission of error was reform of the tort system.

Tort reform is vital if doctors are expected to admit mistakes or openly discuss unexpected outcomes. For example, the imposition of a \$250,000 cap on noneconomic damages would help doctors openly address problems. Currently, doctors live in dread of being sued for lottery-like amounts by trial lawyers.

The imposition of a \$250,000 cap would put some predictability into the compensation system and temper the "gold rush" legal mentality so doctors could admit mistakes without facing the specter of losing their worldly possessions in the process.

Tort reform will help support patient safety efforts. Every medical organization or association should make tort reform an integral part of its patient safety efforts. For the PIAA, tort reform remains a logical and moral imperative.

Lawrence Smarr is president of the Physician Insurers Association of America. Illinois State Medical Inter-Insurance Exchange is a PIAA member.

Coming soon:
Diet
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ISMIE Update

“Classified” information: What physicians must know about hiring, firing

BY CHRIS PETRAKOS

Part 1
of a
two-part
series

Physician liability is not just about medical malpractice any more. Recent newspaper headlines have trumpeted multimillion-dollar verdicts against employers for wrongful termination, sexual harassment and infliction of emotional distress. Physicians who manage a medical practice are running a business vulnerable to the same employment risks as any employer who hires, fires and oversees workers.

Guarding against mounting exposure to workplace lawsuits is a three-step process: know the laws, develop clear office guidelines, be consistent as an employer.

Risk reduction begins with careful hiring procedures. “Start with a solid job description,” said Richard Sperling, MD, a member of the Illinois State Medical Inter-Insurance

Exchange board and president of the Rush North Shore Medical Center medical staff. “Have a firm idea of your standards,” he advised. “Determine what training and skills the position requires, and be specific about work hours, job performance and salary. Then, treat all applicants in an equal and fair manner.”

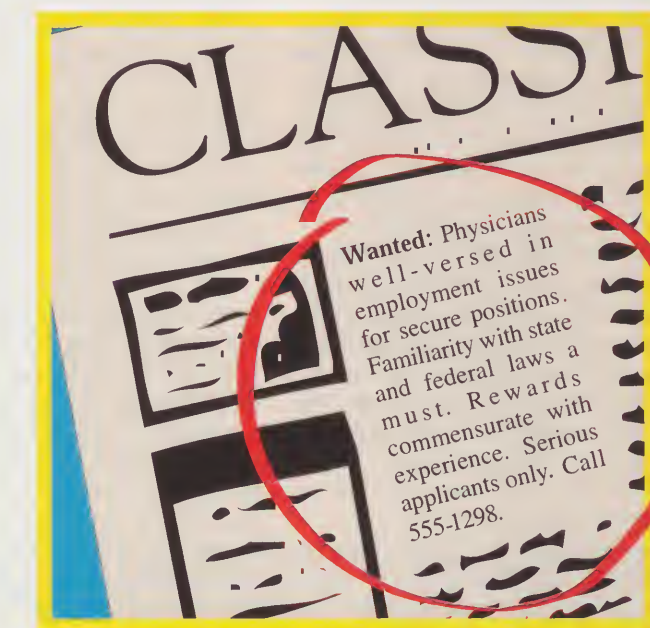
Advertisements and similar recruiting materials must never single out a particular group, said Michael Warnick, an attorney with the Chicago law firm Fedota, Childers and Rocca, at a recent ISMIE seminar, Managing and Reducing Physician Employment and Business Risks. “I’ve seen ads for nurses stating: ‘We’re looking for top women in their field.’ That’s clearly a problem,” Warnick said. Discriminating by such categories as gender, race and religion violates the 1964 and 1991 Civil Rights Acts.

Perhaps the riskiest aspect of hiring a new staff member is the

interview. Warnick explained that there are several areas of questioning employers must avoid, for example those subjects prohibited under the Americans With Disabilities Act.

“An employer can ask whether an individual will be able to meet the essential requirements of a job, but they cannot ask about the nature or the extent of a disability,” he said. Such questions are taboo even in situations where the disability is obvious – for example, if the applicant is in a wheelchair. However, employers are allowed to explain the organization’s attendance policy, and they can ask whether the applicant thinks he or she can be punctual.

So-called privacy questions are another area in which employment interviewing can fall into forbidden territory, Warnick cautioned. Employers cannot ask applicants for their



arrest record or their drinking status. Other questions about after-work conduct having no relation to job responsibilities are also prohibited.

Physicians should be careful not to offer or imply false promises, Warnick said. For example, a physician should not tell the applicant that the mini-

MALPRACTICE ROUNDUP

Patient knew removal of mole would scar, jury finds

A California jury found that a patient knew that the removal of a large congenital pigmented mole on her leg would cause scarring, according to the April issue of Medical Malpractice Law & Strategy.

In Pourrahi vs. Chet, the patient accused her physician of failing to inform her about the possible scarring during the two sessions of laser ablation. She also said the physician burned her leg with overexposure to the laser.

The defendant said the patient had been advised of the risks and complications inherent in the procedure, and had signed a consent form stating that she understood them. The physician also said the patient was partly to blame for the scarring because she failed to maintain her follow-up schedule.

\$44.98 million verdict given for anesthesia negligence

Low blood pressure that went unnoticed during much of a woman’s labor, coupled with excessive anesthesia, caused severe oxygen deprivation to a fetus and resulted in significant disabilities for the child, a New York jury found.

According to the June 15 issue of the National Law Journal, the child’s mother sued her attending obstetrician and settled for \$1 million. The hospital, however, went to court in Asteratakis vs. The New York Hospital. The hospital’s attorney said the labor and delivery were managed by the obstetrician and that there were

no anesthesia-related issues. In addition, the attorney said, tests prior to the birth suggested the child was well-oxygenated.

The child now has a severe seizure disorder, speaks with great difficulty and has only a limited use of her hands and arms. The hospital’s attorney argued that the condition was caused by a progressive neurodegenerative disorder.

The \$44.98 million verdict the Brooklyn jury awarded will be structured, leaving the present value at about \$22 million. The hospital plans to file motions to set aside or reduce the award.

Judgment favors 11-year-old in ruptured appendix case

A California jury found in favor of an 11-year-old plaintiff who charged a pediatrician with failure to diagnose her appendicitis. The defendant was ordered to pay \$70,000; a hospital surgical consultant was found not liable.

According to the May issue of Medical Malpractice Law & Strategy, in Amaral vs. Frank, when the plaintiff arrived at the hospital with left abdominal pain, vomiting and diarrhea, the surgical consultant diagnosed viral gastroenteritis. The next day, the defendant pediatrician agreed with the diagnosis after examining the plaintiff, who later suffered a ruptured appendix.

The plaintiff claimed that her appendix would not have ruptured if her appendicitis had been diagnosed properly. The defendants alleged that, since the plaintiff’s pain was on her left side, her symptoms were not consistent with appendicitis.

mum pay hike employees received during annual reviews was a cost-of-living increase. "The statement creates an expectation that an employee is entitled to a raise at a certain time of year." Another implied promise that should be left unsaid is that none of your employees have ever been fired. There could always be a first, and "that implied promise could come back to haunt you," he said.

Experts cautioned that the process of firing an employee must be well-documented and, when possible, the physician should review both state and federal law to reduce his or her risk of exposure.

"Firing somebody on the spot is bound to get you into trouble," Dr. Sperling said. "And you cannot be too specific when documenting poor performance. You should include the date, the time, the nature of the problem and the fact that you discussed it with the employee." If the problem continues, physicians should explain that if things don't change, the employee will be released.

It is also important to deliver the bad news in a private manner, without embarrassment to the employee. "This is not only the right thing to do," Warnick said, "but it also reduces the risk of an employee coming back and saying you

caused emotional distress."

Warnick recommended the use of exit interviews to document employee departures. The purpose, he said, is that some employees who quit of their own volition later claim their decision was not voluntary. Suggested questions for an exit interview include: Was there any form of discriminatory conduct? Was there any sexual harassment? "If a lawsuit is filed later," Warnick concluded, "the physician can demonstrate with the interview that the employee expressed no dissatisfaction regarding workplace treatment."

To properly protect against employ-

ment and business-practice claims and lawsuits – especially those involving wrongful termination – a physician should develop management policies and procedures that reduce vulnerability. Either that, or take the risk that the next newspaper headline trumpeting an expensive verdict could be about you.

Another ISMIE-sponsored Managing and Reducing Physician Employment and Business Risks seminar will be held Thursday, September 17 at the Collinsville Holiday Inn, Collinsville, Ill. Call (800) 782-4767, Ext. 1327, for more information. ■

Playing by the rules: An employment primer

State and federal watchdogs take a keen interest in hiring and firing practices. The following is an overview of some of the major pieces of legislation setting employment ground rules. Contact your attorney for specific legal advice.

Federal Law

Title VII of the Civil Rights Act of 1964 and the Civil Rights Act of 1991

Prohibits discrimination on the basis of race, color, religion, sex or national origin in the hiring, discharge, compensation and terms of employment.

Section 1981 of the Reconstruction Civil Rights Act

Prohibits discrimination on the basis of race or national origin in making or enforcing contracts that include any form of employment relationship.

Americans With Disabilities Act

Prohibits discrimination based on an individual's disability and requires employers to make "reasonable accommodations" for a disabled person to get or maintain employment.

Age Discrimination in Employment Act of 1967

Protects employees over the age of 40 from discrimination on the basis of age with regard to hiring, discharge, compensation and other terms of employment.

Equal Pay Act of 1963

Prohibits differences in pay between men and women for performance of "substantially equal jobs" unless the differences are due to a factor other than sex, for example a bona fide merit system, training program or seniority system.

State Law

Illinois Human Rights Act

Has parallel protections to federal law prohibiting discrimination on the basis of sex, religion, race, color, age, marital status, disability or national origin.



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REPORT for Illinois Physicians

Viagra (Sildenafil)

Pfizer's drug to treat male impotence has been publicly discussed since its April release. What are the facts as we know them, and what is the BCBS policy for coverage of this product?

Prior to its release, Pfizer studied sildenafil in four populations of impotent males; diabetics, spinal cord injured patients, survivors of radical prostate surgery, and men with psychologically documented impotence. The drug was found to be effective in each population studied.

Ostensibly developed to treat impotence (the inability to sustain an erection during intercourse), the drug is now widely used to treat the newly coined "problem" of mild erectile dysfunction (dissatisfaction with sexual performance by either the patient or his partner). Using a self-assessment of the social acceptability of sexual performance creates a problem. There is no basis in medical evidence for the existence of dissatisfaction with performance as a medical diagnosis. There is also no basis in medical evidence for the success or failure of a personal relationship as a medical problem. There is, therefore, no evidenced-based method for developing medical criteria for drug use in these situations. The personal and social demands that define the need to perform adequately and respond appropriately to partners simply do not define medical necessity.

What evidence exists? Both the Massachusetts Study on Aging (1993) and Pfizer's own data (1998) document that in males ≥ 50 years of age, intercourse attempts of 1-2 x weekly are typical. Pfizer confirmed this observation in patients before and after the use of sildenafil, confirming that in the impotent population, the drug is not an aphrodisiac.

Illinois physicians have, by-and-large, done an excellent job of managing demand for this agent. The average age of males receiving Viagra is 57 years, and the median number of pills per prescription is 8. The policy we are implementing therefore, will impact relatively few patients and physicians. Having surveyed the market, we know that the BCBS policy is somewhat more generous than most. Yet our initial experience with your prescribing patterns convinces us that together we can deal responsibly with unreasonable patient demand for Viagra. For our insured business:

1. Members will be covered for 8 pills per month;
2. We trust that you will continue to limit prescriptions to patients with diabetes, spinal cord injury, radical prostate surgery, and those truly impotent for psychologic reasons.
3. Prescriptions for males < 50 years of age will be carefully scrutinized. Audits revealing inappropriate prescribing will result in administrative actions.
4. Viagra will not be in-benefit for women or for boys < 18 years of age.

We will continue to monitor our experience and advise you of any changes in BCBS policy.

We trust that we can work together to meet the legitimate medical needs of our enrollees while maintaining the integrity of our networks. Our initial experience with Viagra's use in Illinois suggests that our trust is well placed.

Soaking up medical knowledge: Let it COME to you

State mandates continuing medical education credit as part of license renewal.

BY JANE ZENTMYER



Marty Bucella

Every Tuesday for nine months, physicians from the southern-Illinois town of Harrisburg gathered in front of televisions at the Harrisburg Medical Center for their own version of "Must-See TV."

But instead of sitcoms, they tuned in to grand rounds at the Southern Illinois University School of Medicine in Springfield. The live telecast of clinical vignettes and presentations from visiting professors gave the physicians access to the latest medical technologies and breakthroughs — while earning continuing medical education credit close to home.

The weekly program received rave reviews in its first season. "It's absolutely wonderful," said Larry Jones, MD, a family physician who practices at Primary Care Group in Harrisburg, located about three hours south of Springfield. "It's convenient. It's inexpensive, and it's the easiest way I know of to get CME hours, particularly in a small community like Harrisburg."

After a summer break, the off-site learning program will resume in the fall.

Earning CME credit became even more important this year. After years with no specified number of required CME hours, the state's Medical Practice Act requires physicians to earn 150 hours of continuing education in order to renew their three-year medical licenses. Physicians' current licenses expire in July 1999, but the state will only require 50 CME hours this renewal period because the law became effective midcycle. (See sidebar for additional details.)

While long-distance learning may not be available to every physician, CME planners are working to bring programs closer to physicians, accommodating their often-hectic schedules. That's why opportunities to earn CME — without the inconvenience and expense of a long trip or days away from practice and patients — have grown in recent years.

Northwestern University Medical School in Chicago, for example, recently offered programs in the city's suburbs and in Indiana to make earning credit easier for those physicians who don't call Chicago home.

"We're trying to reach audiences in some of the outlying communities by holding programs they might



Highlights of Illinois' CME requirements

- Physicians will need 50 hours of CME for the July 1999 license renewal. Any hours earned after July 1997 will count toward this 50-hour total.
- Physicians are required to earn a minimum of 40 percent of their CME hours in formal, or Category 1, hours. A maximum of 60 percent of the total can be informal, or Category 2, hours.
- The Illinois Department of Professional Regulation will keep tabs on physicians' CME hours through random audits. Although documentation proving they've earned CME hours won't have to be sent with renewal applications, physicians will be required to produce it if IDPR audits their application.
- Physicians can earn the American Medical Association's Physician's Recognition Award to meet their CME goal. The PRA requires 150 hours of CME over three years – at least 60 Category 1 hours and a maximum of 90 Category 2 hours. IDPR will accept the PRA as proof of compliance.
- Within the next several weeks, IDPR will mail physicians a notice that further explains the CME requirements.

like to attend in their own areas, like a dinner or Saturday program," explained Paula Puntenney, director of Northwestern's Office of Continuing Medical Education. Common programs address medical issues in primary care, Ob/Gyn or cardiology.

Given the state's increased emphasis on CME credit, Puntenney added, "some of our hospitals have tried to encourage community physicians to attend weekly meetings." Hospitals in the Northwestern network have doubled their program offerings, opening many to all physicians in the community. "There's been a bit of marketing done by the hospitals to get people in the area to attend local programs."

Attending programs provided by their hospital is a simple way for physicians to earn CME hours, said Dennis Wentz, MD, director of the AMA's Division of Continuing Medical Education. The Joint Commission on the Accreditation of Healthcare Organizations requires physicians to earn a set amount of CME relevant to their specialty, and most hospitals support that requirement with programs like grand rounds and weekly clinical conferences, he said. "That could easily add up," Wentz added.

Earning CME, however, can get even simpler than a visit to the local hospital, office or meeting room. A physician may only need to visit whatever room in his or her house that holds a personal computer. "Internet opportunities are greater now than they've ever been," said Bruce Bellande, executive director of the Alliance for Continuing Medical Education in Birmingham, Ala. "And, the potential is there for even greater growth."

On the Internet, physicians can find listings of organizations' CME programs or sites offering Category 1 CME credit online. ISMS is currently working on revamping its Web site to include Illinois CME opportunities for physicians.

While finding a relevant site among the thousands available on the Internet may seem daunting, the AMA's Web site (www.ama-assn.org) includes a service that helps physicians locate desired CME programs. More than 2,800 physicians in a given week take advantage of this service, which is called the "CME Locator." It can be found on the Web site with other AMA CME information.

To use the locator, physicians input their relevant specialty and the type of CME program they want, then the system searches a database of more than 2,000 Category 1 activities sponsored by accredited providers, and creates a list that fits the physicians' criteria.

Physicians then must identify if they are interested in American, Canadian, or international seminars and workshops, or if they're interested in home study. Under home study, physicians can choose videocassettes, audio tapes, computer disks, journal-based CME, preprogrammed print materials or the Internet.

For example, a home-study search for emergency medicine subjects on the

Internet will yield three choices: Infection Control in the Health Care Office Practice; Advances in the Diagnosis and Management of HIV/AIDS; and Anticoagulation Therapy for the Prevention of Stroke in Atrial Fibrillation. All of these sites offer Category 1 credit.

Physicians can also find other CME programs on the Internet by using online search engines. However, Dr. Wentz gave these words of caution: "Anybody can put anything on the Internet," he said. "Look at who the sponsor is. A CME program should be offered by providers who have received accreditation from the Accreditation Council for Continuing Medical Education."

In addition to the Internet, many other multimedia materials are available. "Some providers have educational opportunities that allow physicians to call in and participate in an audio conference, and some of those are certified for credit," Bellande said. (The AMA's CME Locator can search for many of these materials.)

Reading peer-reviewed journal articles is another popular method physicians can tap to keep current on medical research. Now they can earn Category 1 CME by reading articles and answering questions that are returned to the publication for credit.

Joan Cummings, MD, chairman of the ISMS Council on Education and Health Workforce, said she earns most of her CME credit by reading the New England Journal of Medicine and completing its home-study Category 1 credit program. "Any other CME I do just for the fun of it." ■

IDPR DISCIPLINES

This information, published as space permits, is reprinted from the Illinois Department of Professional Regulation's monthly disciplinary report. IDPR is solely responsible for its content.

April 1998

Robert M. Frankle, Buffalo Grove – physician and surgeon license reprimanded and fined \$1,000 for failing to report test results for a patient, not returning phone calls and being slow in cooperating with the Department investigation.

Suckoo Kim, Northbrook – physician and surgeon and controlled substance licenses placed on indefinite probation and fined \$25,000 for filing false reports

in his practice and acting unethically.

Adolfo F. Molina, Miami, FL – physician and surgeon license reprimanded after being suspended for three months from Medicaid eligibility by the Illinois Department of Public Aid for failing to provide prompt transcriptions of medical records when his medical records were allegedly found illegible, and failing to report this action to the Department.

Percy C. Moss Jr., Chicago – physician and surgeon license reprimanded for failing to note a drop in a patient's hemoglobin and platelet count, and therefore failing to provide treatment prior to discharge. The patient died four days later.

Clarification

The Illinois Department of Professional Regulation has advised that Luis Munoz, MD, Chicago, holds an active physician and surgeon license. Information to the contrary, reprinted from the IDPR monthly disciplinary report, was published in the June 12, 1998 issue of Illinois Medicine. It is the policy of this publication to print disciplinary information exactly as it is received from IDPR.

Sundown for Sunbeam?

(Continued from page 1)

tion, the House directed the AMA board to report the costs related to termination of the Sunbeam contract and all other unauthorized nonmembership commercial contracts, including, but not limited to, the legal costs of investigating and arguing court cases, and final settlement expenses. The House excluded the severance cost of terminated employees from the accounting; testimony against releasing that data indicated it would violate contractual elements of the severance agreements.

Two other ISMS resolutions called for the association to be more open and responsive. The House approved an ISMS proposal for the AMA to fully explain the exact nature of and all pertinent background information regarding the public-private partnership existing between the U.S. Health Care Financing Administration and the AMA. Testimony to the reference committee in favor of the resolution expressed distrust of HCFA, stating that although the agency was created as a financing administration, it has developed into a medical watchdog. There was no opposing testimony.

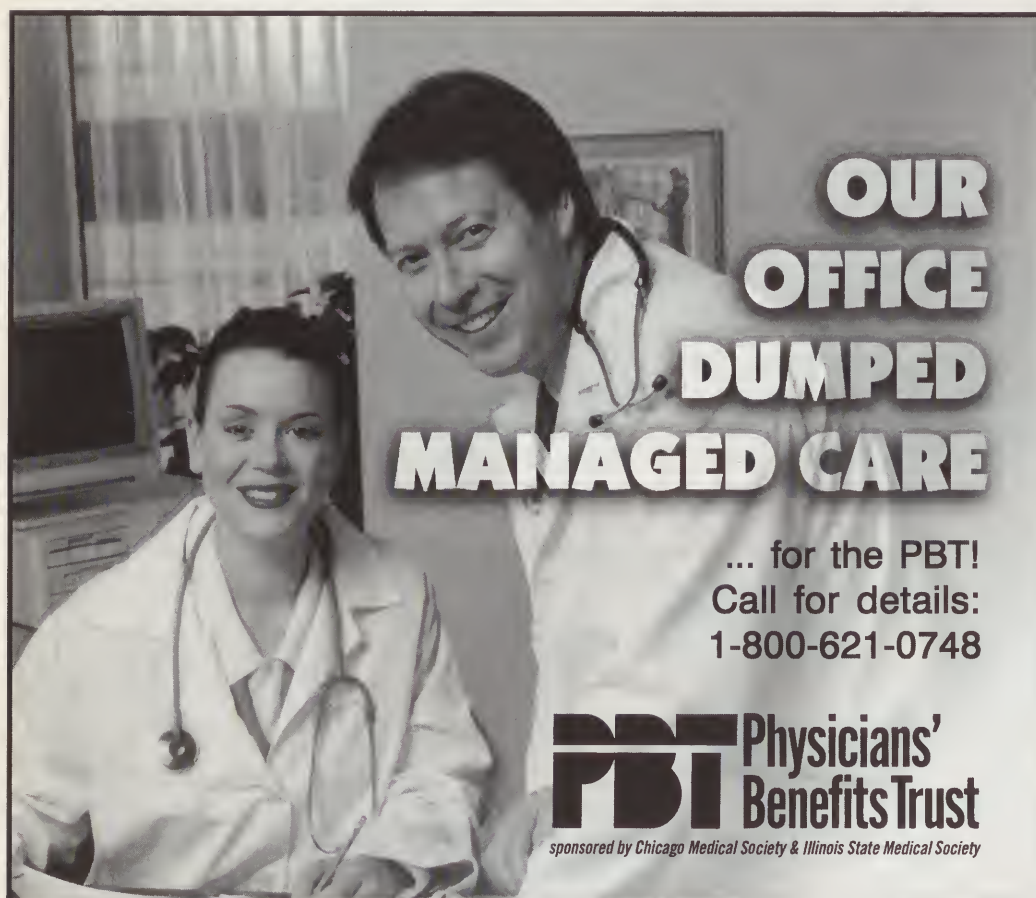
An ISMS resolution asking the AMA to open all board, council, advisory committee and subcommittee meetings to AMA members and representatives of various other organizations was referred to the board. Concern was expressed that the logistics of open meetings might compromise the AMA's effectiveness.

"Each year we get a little more of what we want," said Edward Fesco, MD, chairman of the ISMS delegation to the AMA, explaining that the open meeting issue has been discussed in previous years. "I hope the new board will address and better deliver on our requests," he added.

Another Sunbeam ramification was the vigorously contested election for the position of president-elect between Thomas Reardon, MD, who was chairman of the board during the past year, and reform candidate Raymond Scalettar, MD. Dr. Reardon eventually won. The competition actually worked to the AMA's benefit, Dr. Fesco said. "Instead of the usual rubber stamp, it caused a lot of buzz," he explained. "Everyone was thinking and talking. The two candidates had to campaign and answer questions. I asked both of them how they would get rid of E&M coding."

What bearing, if any, the AMA's Sunbeam response will have on the pending issue of possible ISMS deunification is yet to be determined, Drs. Geline and Fesco agreed. Dr. Geline said he believes few physicians will let the Sunbeam episode sway their opinion on unification. "More likely, they will use Sunbeam to either support or oppose unification, depending on where they stand on the issue in the first place," he said. "Physicians who favor unification might say the AMA did a good job with a tough problem. Unification opponents could say they didn't handle it well."

Dr. Geline pointed out that the deunification issue has been considered in Illinois for many years. The difference this time is that a special committee has been formed to investigate the proposal. At its last meeting, June 27, the ISMS board authorized a special House of Delegates meeting on the matter that could be called if the committee completes its investigation prior to initiation of the 1999 billing cycle. ■



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Chicago medicine's past explains present, guides future

HISTORY: Classic book captures the colorful, complex and controversial story. BY JANICE ROSENBERG

[CHICAGO] Busy Illinois physicians have little time to contemplate their predecessors. Nevertheless, the complex history of medicine in general, and Chicago medicine in particular, informs the work of today's physicians and can serve as a guide for the 21st century.

"If Chicago medicine is to be better prepared for the future, it is required that its past, remarkable and glorious, be recovered," said noted historian Thomas Bonner, PhD, visiting professor in history and higher education at Arizona State University. "Today, what's needed most is perspective. How did present problems and controversies emerge? Can we trace, in the events of the last half century, the roots of contemporary issues?"

Bonner spoke recently on "A Century of Chicago Medicine" at the 83rd annual meeting of the Institute of Medicine of Chicago, held at the Newberry Library. His book, "Medicine in Chicago 1850-1950: A Chapter in the Social and Scientific Development of a City," is considered a classic in medical history and, according to the institute, is the most detailed study of its type ever made of a major American city.

records, minutes and files. He completed the book on schedule in June 1950. It detailed the lives of the city's first physicians; efforts to fight cholera; the 1843 founding of Chicago's first medical school, Rush Medical College; the efforts of late 19th-century physicians to fight epidemics (at a time when children under age five accounted for 71 percent of all Chicago deaths); the 1910 Flexner Report on Medical Edu-

cation and its effect on Chicago's many medical schools; and the 40 years of medical school and hospital consolidation that followed.

Bonner gave the manuscript to CMS for approval by his dissertation committee and returned to his graduate studies. CMS published a shortened volume of the book, but not until 1957.

The book finally appeared in its entirety in 1991, when the University

of Illinois Press brought out a second edition. By then, Bonner was well along in a distinguished academic career that has included eight other books, a Fulbright lectureship and the presidencies of the University of New Hampshire, Union College and Wayne State University.

Bonner has not lost his interest in Chicago's strong medical organizations and personalities. He is both surprised and disturbed that in Chicago today there is not a single university program on the history of medicine. "Why are there no medical historians in Chicago?" he asked. "Chicago should make an effort to maintain its medical history." ■



Thomas Bonner, PhD

The book's publishing history embodies what Bonner called the "colorful, complex and controversial story of Chicago medicine." In 1949, the Chicago Medical Society decided to publish a book recording its history and commemorating its 1950 centennial year. J. Roscoe Miller, MD, then president of CMS and dean of Northwestern University Medical School, approached Northwestern's history department looking for a writer. With the topic broadened to include the history of all medicine in Chicago, and financed by a CMS fellowship, the project was offered to Bonner, then a graduate student in American history.

Bonner had not finished his doctorate at that point, but, as a young scholar, he found the project fascinating and the prospect of guaranteed publication irresistible. He took a year off from his studies to work on the book, which would ultimately serve as his doctoral dissertation.

"I was woefully unprepared. I knew nothing of medicine, its history or the sources for the study," Bonner said. "I immediately began an exhaustive regimen of reading about the histories of both medicine and Chicago."

During 1949 and 1950, CMS provided Bonner with full access to all of its

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E&M debate

(Continued from page 1)

"Let's do away with quantification. Let's stay with peer review," said John Schneider, MD, an Illinois AMA delegate, earning the House's applause. "Use whatever mechanism one wants to screen cases, but require peer review by a physician so he or she can make a judgment that reflects the quality and complexity of the care provided."

The House's decision to ax quantitative elements from the E&M guidelines defied recommendations from the AMA's leadership, who warned that HCFA was likely to ignore the House's action and include some type of quantification in the guidelines. AMA President Nancy Dickey, MD, at the House meeting said, "The real question is, [will this] be quantification we know and negotiate? Or [will this be] quantification in a black box that reviewers use, but we're only guessing what it really means?"

However, the House also directed the AMA to continue its work with HCFA to develop new, simplified guidelines. By working with HCFA, the AMA can ensure it has a seat at the table as the guidelines take shape, said Edward Fesco, MD, chairman of the Illinois AMA delegation. Dr. Fesco described the choice the government gave physicians as, "Do you want to help or do you want to lie there while we walk over you?"

HCFA's Dr. Berenson said that regardless of the outcome of the agency's discussions with the AMA, HCFA must move forward to refine and implement a set of documentation guidelines.

Linking fraud and abuse to the complex E&M documentation guidelines also generated concern among AMA delegates despite previous reassurances from HCFA. Nancy-Ann Min DeParle, HCFA administrator, said in an April letter to the AMA that "physicians will not be punished for honest mistakes, and we will not make referrals to the Office of the Inspector General for occasional errors."

AMA delegates urged the AMA to stand firmly committed to eradicating true fraud and abuse, but also put forth principles for the AMA to follow when opposing inappropriate penalties or prosecutions. Physicians should be given the same due process protections under the Medicare audit system or federal investigations given to all U.S. citizens.

Other key points in the adopted resolution encourage the AMA to:

- Seek congressional action enacting a "knowing and willful" standard in the law for civil fraud and abuse penalties regarding coding and billing errors and insufficient documentation.
- Support adequate testing of revised guidelines and grant physicians in any pilot test immunity from Medicare sanctions and penalties.
- Urge HCFA to discontinue random prepayment audits of E&M services.
- Take action to preserve the confidential medical record as an instrument of clinical care and oppose its use as an accounting document.
- Eliminate financial or legal penalties based on one level of disagreement in E&M code assignment.
- Work with state medical societies and national medical specialty societies to develop documentation tools to assist in the guidelines' implementation, including disseminating information through the AMA Web site.



Ted Grudzinski/AMA

NO CHECK LISTS. "Let's do away with quantification," John Schneider, MD, (left) former chairman of the ISMS Third Party Payment Processes Committee, said at the AMA annual meeting. He spoke against E&M coding proposals that would let government-generated lists dictate patient care.

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Physicians lobby

(Continued from page 1)

coverage of the fly-in.)

Physicians can participate in the national lobbying effort by expressing their opinions to their U.S. representatives and senators, said ISMS President Richard Geline, MD. "Pressure from the local level will be instrumental in getting action [from lawmakers] when the vote comes up."

The most recent federal managed care reform proposal came from the House Working Group on Health Care Quality, a Republican task force led by U.S. Rep. J. Dennis Hastert (R-Ill.). As this

issue of Illinois Medicine went to press, the proposal's concepts had not been incorporated into formal legislation, but such legislation was expected imminently.

While the working group's plan is a good start, the AMA said, key improvements would increase the proposal's chances for passage and strengthen its patient protections.

For example, the working group has proposed including medical malpractice reforms like caps in its plan.

The caps' inclusion, however, could jeopardize the passage of a patient rights bill. Organized medicine believes the two issues should be kept in separate bills. (See sidebar for additional details.)

Hastert, however, feels strongly that medical malpractice reform is a critical piece of health care reform, according to a spokesperson. "If we truly want to hold down costs, it has to be part of the puzzle," he said.

He acknowledged that malpractice caps [are] a point of contention between the White House and the Republican Congress, but denied that including it in health care reform is an attempt to kill the bill.

The working group's plan also fails to address physician concerns about the liability exemption self-insured health plans enjoy thanks to the Employee Retirement Income Security Act of 1974. Self-insured health plans cannot be held to state medical malpractice and consumer protection laws.

"This exemption makes the doctor one of the only targets of a lawsuit when, in fact, decision-making is often not in the doctor's hands," Dr. Geline

Key improvements would increase the proposal's chances for passage and strengthen its patient protections.

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Poison pill

(Continued from page 1)

enough political support.

"They are killing us with kindness," said ISMS President Richard Geline, MD. "By linking the two causes, some legislators are seeking to kill the bill entirely. They are trying to satisfy their own political agenda by saying they supported the legislation, while knowing it won't pass."

Unfortunately, physicians saying no to caps in this instance gives the impression that they do not want tort reform legislation at all, said Dr. Geline. "Yes, we want caps and we want managed care reform. Philosophically, they're both necessary; they're both important. But tactically, linking the two is the equivalent of killing the managed care bill."

In fact, ISMS has long been a tort reform leader in Illinois, Dr. Geline said. "It is best to pursue caps separately so as not to jeopardize patient rights reform."

said. A meaningful reform bill would erase the ERISA exemption and allow patients to sue their health plan if its decision caused their injury.

Hastert defended the Republican ERISA stance, which he said is designed to keep health care "in hospital rooms, not courtrooms. We believe that our accountability features – expedited internal review and external appeals to independent medical experts – will be able to provide the patients the care they duly deserve when they need it."

This is in contrast, Hastert said, to those who would want any differences between patients and their insurance company resolved many months, even years later.

Other pending managed care reform bills – specifically one sponsored by Reps. Greg Ganske (R-Iowa) and John Dingell (D-Mich.) in the House and Sen. Thomas Daschle (D-S.D.) in the Senate – offer much stronger patient protections. For example, the Ganske-Dingell bill holds health plans accountable for denying necessary treatment. ■

Call the AMA at (202) 789-7467 and ask for your regional political director, or ISMS at (312) 782-1654, Ext. 1142, for information on contacting your congressman. You can also access the AMA Web site at <http://ama-assn.org/grassroots>.

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ARASSMENT IN THE WORKPLACE (PAGE 6)



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PAGE 7

Illinois Medicine

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eyes
governor's
office

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Physicians take rights fight to Hill

MESSAGE SENT: Enact reform now. BY JANE ZENTMYER

[WASHINGTON] ISMS leaders recently joined physicians from across the country, descending on Capitol Hill to give their U.S. congressmen an earful about the need for a meaningful patient rights bill.

The American Medical Association organized the lobbying effort to educate lawmakers preparing to vote on a federal patient rights bill. The AMA asked state and county medical societies for help.

"If a proposal provides good patient care, it deserves our support," said ISMS President Richard Geline, MD.



Dr. Geline (left) and President-elect Clair Callan, MD.

"The principles in a national bill must be compatible with policies approved by our ISMS House of Delegates."

Dr. Geline, President-elect Clair Callan, MD, and past chairman of the ISMS Board of Trustees M. LeRoy Sprang, MD, met with eight Illinois Republican representatives in Washington, D.C., July 21 to make the case for key reforms. This followed meetings ISMS held with some Illinois congressmen in their home districts.

Lawmakers agreed with most concepts, Dr. Sprang said, such as banning gag rules, implementing an external appeals process, mandating a prudent layperson definition for emergency services and requiring disclosure of a health plan's policies.

A key player ISMS leaders visited was U.S. Rep. J. Dennis Hastert (R-Ill.), chairman of the House's Working Group on Health Care Quality and GOP point man on reform. Hastert's group spent six months developing the Republican patient-rights proposal.

Physicians voiced concerns to Hastert that the GOP plan fails to eliminate the exemption from state medical malpractice laws health plans currently



From left, GOP point man U.S. Rep. J. Dennis Hastert (R-Ill.) listens as ISMS President Dr. Geline and former Board chairman Dr. Sprang make the case for a meaningful patient rights bill. Republicans' stance on ERISA exemptions and malpractice caps were points of disagreement.

enjoy under the Employee Retirement Income and Security Act of 1974.

Republicans argue against cutting ERISA exemptions, saying they want to create a patient bill of rights, not a trial lawyer's "right-to-bill." The GOP claims it holds health plans accountable for their decisions by establishing expedited internal reviews and allowing external appeals to independent medical experts. Patients need care "in hospital rooms, not courtrooms," Hastert said.

But patients suffer because health plans have no legal accountability for their decisions, Dr. Sprang said. "We believe

(Continued on page 10)

HCFA to release rules aimed at simplifying transactions

IN PROGRESS: New plan eliminates paperwork, includes national patient ID. BY JANE ZENTMYER

[CHICAGO] As savvy physicians make their office computers resistant to the Year 2000 bug, they should also be ready to meet new government electronic-transaction standards.

In coming months, the U.S. Health Care Financing Administration will nudge the health care industry deeper into the Information Age when it implements administration simplification provisions in the Health Insurance Portability and Accountability Act.

These provisions could save the industry an estimated \$1.5 billion during the first five years, HCFA said, eliminating reams of paperwork and bureaucratic processes that clog the system.

A controversial portion of the provisions – the creation of a national patient identifier –

has attracted national attention. Skeptics argued the identifier would make it easy for the wrong person to access and misuse confidential medical information. Proponents, though, said IDs would improve coordi-

(Continued on page 10)

New carrier hopes to come in like a lamb...

[CHICAGO] Although some physicians doubt the huge task of introducing a new Medicare Part B carrier to Illinois will come off without a hitch, officials in charge of the transition say the only difference users will notice is the name on the door.

The move to Wisconsin Physicians Service, which kicked in Aug. 1, should barely be noticed, said Ed Beilfuss, contractor operations officer for the U.S. Health Care Financing

(Continued on page 8)

...As old carrier goes out like a lion

As Illinois' outgoing Medicare carrier exits its state contract draped in scandal, company representatives insist physicians were not, and will not, be affected by the fraud.

"The impact to physicians is transparent," said Allan Korn, MD, vice president and chief medical officer at Blue Cross Blue Shield of Illinois, which until this month processed Illinois Medicare claims under the name Health Care Service Corp. HCSC announced last December it would discontinue its Illinois Medicare contract, and effective Aug. 1 turned the business over to Wisconsin Physicians Service.

Despite media reports to the contrary, Dr. Korn insisted

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MEDICINE

Revised Medicare pay plan emphasizes office-based services

HCFA: Another stab at practice expense values. BY JANE ZENTMYER

[WASHINGTON] The newest version of Medicare practice expense values continues the shift of federal monies from hospital-based services to office-based services. In June, the U.S. Health Care Financing Administration released these revamped values – just over a year after a previous revision ignited a controversy

that didn't subside until Congress told HCFA to try again.

"Clearly, some physicians are heavily impacted [by the revision]," stated John F. Schneider, MD, former chairman of ISMS' Third Party Payment Processes Committee. But, he said, any change in physicians' incomes will be linked to

their patient mix. Some care for more Medicare patients than others and may see income changes as a result.

The new values will be phased in over four years to lessen the impact on physician income, according to an ISMS analysis. Comments on the new proposal will be taken until Sept. 3, 1998, and HCFA plans to begin implementing the values in January 1999.

Practice expenses, which include costs like office staff and equipment, account for about 41 percent of the Medicare fees paid to physicians. (Their work and liability costs make up the rest.)

As proposed, the four-year impact of the revised practice expense values will

cause the greatest Medicare pay increases for dermatology, 27 percent; rheumatology, 15 percent; and ophthalmology, 11 percent. The greatest reductions will be for cardiac surgery and gastroenterology, 14 percent; and cardiology, emergency medicine, radiation oncology, radiology and thoracic surgery, 13 percent.

Cost changes for specific procedures will vary. For example, the fee for an office/outpatient visit for an established patient (coded 99211) will increase 27 percent if performed in an office-like setting and 23 percent if performed in a hospital-like setting. The fee for a diagnostic colonoscopy (coded 45378) will increase 1 percent if performed in an office-like setting and drop 28 percent if performed in a hospital-like setting.

To calculate the actual physician payment, HCFA assigns a relative value to the practice, work and malpractice portions of the fee. The values are adjusted to reflect geographic cost differences and then added together to reach a total. That total value is then multiplied by a "conversion factor" to transform it into the dollar amount Medicare will pay for the service.

HCFA's revision uses a new, "resource-based" methodology to develop practice expense values. This recognizes actual costs of the resources physicians need to furnish a service. The change reflects HCFA's belief that its previous approach favored procedures and tests performed in hospitals and similar settings rather than those performed in office settings.

In anticipation of the shift that would occur once HCFA begins implementing the values, Congress included a one-time down payment of \$390 million toward office-based services in last year's Balanced Budget Act.

A 1994 federal law originally required HCFA to implement the new resource-based practice expense values by 1998. However, its initial revision received strong criticism from organized medicine, which argued HCFA used flawed data to determine physicians' actual practice expenses. Subsequently, Congress included a one-year implementation delay in the Balanced Budget Act of 1997.

The delay gave HCFA time to redo the resource-based values. Among other things, the 1997 law requires new values to be derived from generally accepted accounting principles recognizing all staff, equipment, supplies and expenses – not just those tied to specific procedures. When developing the new values, HCFA was also required to consult with organizations representing physicians.

Timothy Flaherty, MD, an AMA trustee, called the proposed rule an improvement over last year's disputed proposal. "The new proposed values now more accurately reflect differences in specialty practice costs," he said. ■



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REPORT for Illinois Physicians

CARE-VALUE PATHWAY: Cellulitis

as of 7-1-98

Key Opportunities

Some patients may only need one day of close observation.

Admission Criteria

Patients with skin erythema and fever may be admitted. Patients with compromised immunity, uncontrolled diabetes, or, at the extremes of age (< 2 years or > 65) may need admission.

Note: Patients not meeting these criteria may not need admission; outpatient oral antibiotics with follow-up is a reasonable alternative treatment plan.

Optimal Length of Stay

1 - 2 days, unless there are conflicting or co-morbid factors.

Pathway A: Patients who primarily need close observation

Day 1

Any skin exudates are cultured at admission. Co-morbid factors (e.g. uncontrolled diabetes, pedal edema) are vigorously treated.

Discharge criteria

Patient has a fever of less than 100.5 orally. Erythema is subsiding. Complete resolution of erythema or swelling is not medically necessary for discharge if adequate outpatient follow-up is possible and arranged.

Pathway B: Patients who need sepsis ruled out

Day 1

Blood cultures are drawn at admission, and the patient is put on parenteral antibiotics. Any skin exudates are cultured at admission. Co-morbid factors are vigorously treated.

Day 2

Antibiotics are continued. Co-morbid factors continue to be vigorously treated.

Discharge Criteria

Patient has a fever of less than 100.5 orally. Erythema is subsiding. Blood cultures return negative at 48 hours. The patient is switched to an oral broad-spectrum antibiotic with activity against the specific pathologic organism or against staphylococcus or streptococcus organisms. The patient may then be discharged. Complete resolution of erythema or swelling is not always medically necessary for discharge.

Case Management/Disease Management Focus

Close office or home health follow-up of body temperature and skin healing as well as attention to any co-morbid conditions.

Reference

[N. Gantz, Manual of Clinical Problems in Infectious Diseases, 2nd ed.]

Democratic U.S. Rep. eyes governor's seat

ON THE CAMPAIGN TRAIL: Glenn Poshard speaks out on managed care, tort reform. BY JANE ZENTMYER



Part 1 in a series profiling key Illinois candidates & races.

In the upcoming November election, Downstate Democrat Glenn Poshard will try to deny a Republican the Illinois governor's office – a feat that has thwarted Democratic candidates for more than 20 years. Poshard, 51, won a feisty, four-way Democratic primary and now

faces another tough opponent, Republican Secretary of State George Ryan.

As a five-term U.S. Representative, Poshard is well known in his Congressional district, which includes all or parts of 27 counties in Central and Southeastern Illinois. Many physicians living in the district cite Poshard's work ethic and his desire for first-hand information as reasons for their strong support of his gubernatorial bid.

"He wants to know what's going on, what doctors and hospital administrators are thinking," said Jim Turner, DO, a family physician at Cork Medical Center in Marshall. "He comes to offices and hospitals to visit. He's very helpful if you call his office for things like helping someone with a disability or other medical problem."

One issue voters are focusing on this election season, according to political analysts, is managed care reform. Poshard said many people have told him they believe managed care companies emphasize profit margins over quality care.

"People feel very strongly that managed care plans don't treat them appropriately, that people who are not health care professionals are making decisions and that doctors are too limited in terms of what they can and cannot do," Poshard said.

During the primary, Poshard proposed a patient bill of rights that includes reforms such as requiring full disclosure of benefits, exclusions and patient costs; eliminating prior approval for emergency room visits; and providing patients with a reasonable choice of primary care physicians, specialists and hospital facilities.

As this issue of Illinois Medicine went to press, the U.S. Congress was debating the merits of competing federal patient bills of rights. Poshard cosponsored H.R. 3605, legislation backed by organized medicine as best addressing physician and patient concerns. It failed July 24 in a virtually party-line vote, 212 to 217.

Even if Congress approves a federal reform bill, Poshard said Illinois may still need to pass its own. "I can't conceive of a federal bill passing that would be flexible or broad enough to cover the concerns of each individual state."

Another issue of importance to physicians is the need for tort reform, especially caps on noneconomic damages. Poshard, who voted for caps as a U.S. Representative and who supported caps in the primary, has changed his position.

"At one time, I favored malpractice caps and voted for those because promises were made that if caps were available premiums would come down," Poshard said.



ON THE STUMP: Illinois Democrat U.S. Rep. Glenn Poshard (left) made a recent Downstate campaign appearance in his bid for the governor's office. Health care issues – including managed care reform – are an intensifying focus of the gubernatorial race.

But, he added, "I haven't seen that happen, and so I would not support caps. I have not seen [caps as] being effective in terms of bringing down the cost of medical malpractice insurance."

In 1995, the Illinois General Assembly passed historic tort reform, including a \$500,000 cap on noneconomic damages, which Gov. Jim Edgar, a strong

supporter of caps, signed. Plaintiff attorneys immediately challenged the law; the Illinois Supreme Court ruled it unconstitutional last year.

Poshard has always backed improved rural health care. He's cochairman of the Rural Health Care Coalition, which successfully spearheaded a bid to increase federal funding for tele-

medicine and improved rural Medicare payment rates.

Several groups have recognized Poshard's efforts to improve rural health care. The National Rural Health Association honored Poshard with a legislative award for his work in Congress. The Illinois Hospital and HealthSystems Association gave him three legislative awards for his work.

*As a U.S. Rep.,
Poshard voted for
malpractice caps
... but has changed
his position.*

Before winning his current position in Congress, Poshard served in the Illinois Senate from 1984 to 1988. Poshard holds a doctorate in administration of higher education from Southern Illinois University and has been a teacher, coach and educational administrator. A veteran, he received a Meritorious Service Award for outstanding service to the U.S. Army in Korea.

Critics have said Poshard's Downstate roots and conservative leanings won't appeal to voters in Chicago and the suburbs. Many have cited his position on guns, in particular his vote against an assault-weapon ban, as an issue that will hurt him with the electorate.

But with Poshard, "what you see is what you get," Dr. Turner said. "If you asked me, 'Do you want someone who agrees with you on every issue or do you want someone who is going to work hard for you and be honest?' I'd take the hardworking, honest guy any time." ■

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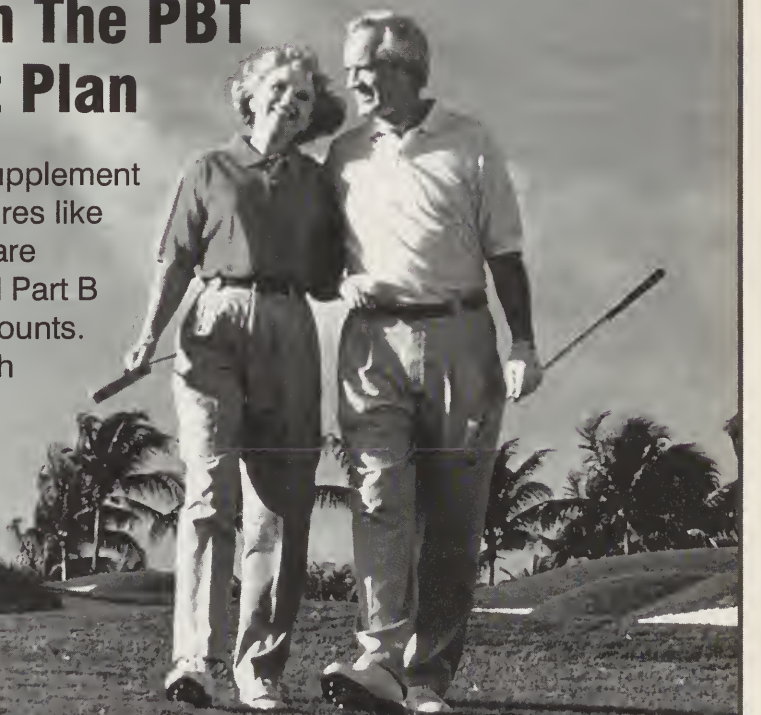
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EDITORIAL

Charting the best course to patient rights

At no time since the invention of Medicare has a health care issue seemed to dominate the attention of lawmakers in Washington, D.C. as has the current debate over a patient bill of rights. Events unfolding in recent weeks, including the President's unprecedented visit to the American Medical Association, underscore the sea change the issue is currently undergoing.

Elected officials addressing this issue aren't just *acting* for constituents, they are *reacting* to a tidal wave of outrage against managed care abuses now drowning the nation. About three-quarters of Americans believe health care reform should be a top priority for Congress, according to a recent Time magazine survey. Only 40 percent said they were "very confident" their health care plan would pay for treatment if they became seriously ill.

Organized medicine is playing an integral role in shaping the improvements in our health care system. As part of an AMA-led lobbying effort, ISMS has been knocking on Congressional doors and itemizing for legislators the reform measures it believes are key to meaningful change: information disclosure, access to emergency services, access to specialists, independent appeal of utilization decisions, point of service options, gag-clause bans and patient permission to sue health plans.

Although still far from a safe harbor, legislative proposals considered in the last

few weeks have inched reform forward. Physicians must keep their fingers on the pulse of reform – i.e. contact your legislators – to help ensure passage of the strongest reform law that is politically possible.

The course to federal patient rights reform is still being charted and will likely experience numerous adjustments in upcoming weeks. One plan, proposed by Republicans, passed the House; a Democratic version was narrowly defeated. Now the debate moves to center stage in the U.S. Senate.

It's clear from all the wrangling that if a final product is to emerge, it most likely will be a compromise of political interests. Organized medicine has shown willingness to compromise by agreeing that malpractice caps tort reform not be included in a patient rights bill for fear it would kill the entire bill.

While compromise is acceptable, collapse is not. Legislators will make a drastic mistake if they stop short of creating a comprehensive law to protect patients. Americans will not be fooled by – and will likely vote against – politicians proposing bills that either are substantially weakened or never make it into law. They will not settle for either political party saying it tried to do something, but floundered because the other side of the aisle wouldn't let it. As one ISMS leader who visited Washington, D.C. put it: "Americans don't want a bill, they want a law."

PRESIDENT'S LETTER

Message to Washington: Reform managed care now

Richard A. Geline, MD



We would rather be fighting disease than insurance bureaucrats.

Over the last few weeks, ISMS was in the thick of the battle to win a federal patient rights bill. As part of a nationwide AMA effort, we went to Washington, D.C. to tell Congress about struggles physicians and their patients face daily to keep health care decisions in the hands of medicine, not business. Prior to going to Washington, I wrote the following essay explaining why the time for managed care reform is now.

New management at his HMO requires an 81-year-old man with hypertension to accept a cheaper drug, and his blood pressure shoots up. Eventually, a local physician provides him with a free supply of the original drug that the man cannot afford on his own.

After chemotherapy fails, a 13-year-old cancer patient's father is forced to launch a fundraising drive to get his son a bone marrow transplant that his HMO decided was not a "medical necessity."

A woman searching for a new health plan to cover her daughter for a heart defect is told by an agent that a local HMO will cover her child's pre-existing conditions. But two months later, when the girl needs surgery, the HMO announces a two-year minimum for pre-existing conditions and refuses to pay. Taxpayers are forced to pick up the bill through a state program.

And that's just what was reported in one week.

Congress appears ready to act on managed care abuses. Congressmen and senators from both parties have heard from the people they represent, and they have heard far too many stories like these (from the July 13, 1998, Time magazine). In some managed care plans, profits seem more important than the quality of services patients receive.

Doctors want our patients protected from managed care abuses, so we are urging Congress to pass a law that will attack the roots of the disease. So far, there is only one bill – the Patients' Bill of Rights (H.R. 3605 and S. 1890) – that will fix what can go wrong with

managed care without reversing the progress we've made toward limiting the growth of health care costs.

Any bill Congress passes should protect your right to truthful and candid health care by banning insurance gag clauses and practices. It should uphold your right to know all the details of your plan and its policies. It should establish your right to an external, independent review of your case when you have been denied a medical procedure. It should assure you the right to get emergency services when you reasonably believe you need them.

Most importantly, reform must close the loophole in federal law that denies 125 million Americans the right to hold their health plans accountable and liable for the decisions plans make to deny care. It's time the health insurance business lived up to the same standards of consumer protection the law provides for virtually every other industry in the nation.

Health insurance is ready for reform. A Time/CNN poll found 76 percent of Americans want health care reform to be a high priority for Congress. Between 63 and 79 percent support specific reforms like those in the Patients' Bill of Rights. Another poll found 67 percent willing to spend more for patient protections. Fortunately, the amount needed will be minimal. Independent studies by Coopers and Lybrand and others show that patient protections are very affordable. Most items add no more than pennies per month to average premiums. The insurance lobby's complaints about the cost of reform just don't add up.

Doctors don't just hear managed care abuse stories, we live them along with our patients. Many times, a doctor's advocacy effort is all that keeps a patient's managed care problem from becoming as dramatic as the ones that make national news. We would rather be fighting disease than insurance bureaucrats, and our patients need to be concentrating on recovery rather than reimbursement.

It's time for managed care reform.

These kids know the risks of smoking

While adults debate whether celebrities' smoking habits encourage kids to light up, some students have already decided smoking is not for them.

That's what approximately 8,600 students from across the country, including more than 200 from Illinois, said in essays they submitted to the AMA's Resident Physician Section anti-smoking writing contest.

While 80 percent of America's teens have smoked at least once, and 20 percent eventually become smokers, these sixth-, seventh- and eighth- graders committed themselves to staying away from smoking.

Challenged to think about its many risks, they put their thoughts into words using the theme, "smoking is not for me."

The Illinois State Medical Society's Resident Physicians Section's Board of Trustees member Robert Oliver, MD, volunteered to head the Illinois effort. Dr. Oliver, along with medical students, helped judge the Illinois essays written during the past school year.

The Illinois winner was sixth-grader Kim Dignan of St. Gerald School in Oak Lawn, who won a \$100 savings bond.

Kim's winning essay reads:

Smoking is not for me
That I hope you all can see
Smoking does not make people look cool
It makes a person look like a fool
Smoking puts you at risk for cancer
Why people smoke I cannot answer
If you buy a pack a day
You'll end up smoking your life away
Now hopefully you all can see
Why smoking is not for me

Kim

— Kim Dignan, sixth-grader
St. Gerald School, Oak Lawn

Other essay excerpts reinforce children's negative impressions of smoking:

I went home from school one day
and this is what my friends had to say,
"Come on, Emily, be cool,"
(And little did I know that I was the fool),
I said, "What the heck"
and took a drag,
but after one puff I began to gag.
My friends said it would make me mellow
but all I got were teeth of
yellow. . . .

Emily

— Emily, sixth-grader
St. Ambrose School, Godfrey

Smoking is something that I do hate
But it is like everyone is doing it and
I can't escape

When I walk down the street someone has
it in their hand

Well, it's time for someone to take
a stand! . . .

Jennifer

— Jennifer, sixth-grader
Henry H. Nash Elementary, Chicago

. . . When I get older, someone tries to give
me a cigarette or tobacco I will say no
because of all the causes and problems
and diseases, etc. that it gives me. I hope
that if someone you love smokes that you
tell them to quit after you tell them all
the causes of smoking. . . .

Catherine

— Catherine, sixth-grader
St. Gerald School, Oak Lawn

. . . My parents are very heavy smokers
and try to quit but can't. They won't try
any gum, patches, or even a pill to help
them stop them from smoking. My par-
ents say they can stop by themselves
but I already know they can't. Me and
my sisters hate when they smoke
around us because we do not like the
fumes they give off.

. . . One more reason I don't smoke is
because I don't want to die from get-
ting lung cancer. I also tell my parents
this but they just don't listen. . . .

Nicholas

— Nicholas, eighth-grader
Oscar Mayer School, Chicago

. . . My neighbor, (a dad of four just like
my dad) whose kids are ages 15 to 8, he
could die today or tomorrow just because
he smoked all his life. That is all he did, but
now it could and might take his life today.
He is only 43 years old. That would leave a
single mother taking care of four kids, and
all he did was smoke. He didn't commit
any crime. All he did was be a great father
to all of his kids. . . .

. . . The dad I am speaking of passed away
from lung cancer on November 17, 1997.

Jacob

— Jacob, seventh-grader
Mahomet-Seymour Jr. High, Mahomet

. . . So in conclusion, I just wish that
smoking would be completely wiped off the
earth. I wish that we could find some oth-
er type of pleasure that won't kill or effect
you as much.

David

— David, eighth-grader
Oscar Mayer School, Chicago

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ISMIE Update

Sexual harassment in the workplace: Employer's best defense is prevention and policy

BY CHRIS PETRAKOS

Part 2
of a
two-part
series

Workplace sexual harassment has been a news maker lately.

Employers—corporations, small businesses and physician employers—increasingly face this truth: anyone running a business,

including a physician in private practice, may be held responsible for not only their own actions, but those of their employees.

Further, without a sexual harassment policy in place, or by not aggressively following one already in place, physician employers are exposing themselves to lawsuits.

Two recent Supreme Court decisions—*Burlington Industries v. Ellerth* and *Faragher v. City of Boca Raton*—will in many ways change the health care employment landscape. Because of these rulings, physician employers are more likely to be held “vicariously liable” for employees’ conduct, even when the physicians are unaware of any harassing behavior.

It is imperative, then, for physicians to establish and evaluate office procedures for handling sexual harassment issues.

But where to begin? As one expert phrased it, the best defense against liability is a good offense: management training; an effective, well-publicized sexual harassment policy; prompt and appropriate discipline for violators; and protection against retaliation.

A firm foundation for this defense is a zero-tolerance policy. That’s the approach of Keith Brown, DO, chief medical officer at Elmhurst Clinic, where all employees receive a handbook containing a section on the clinic’s harassment policy. Dr. Brown said the handbook “makes employees aware they don’t have to tolerate sexual harassment.”

According to Dr. Brown, the handbook also explains the clinic’s grievance-filing procedure, which triggers a formal investigation.

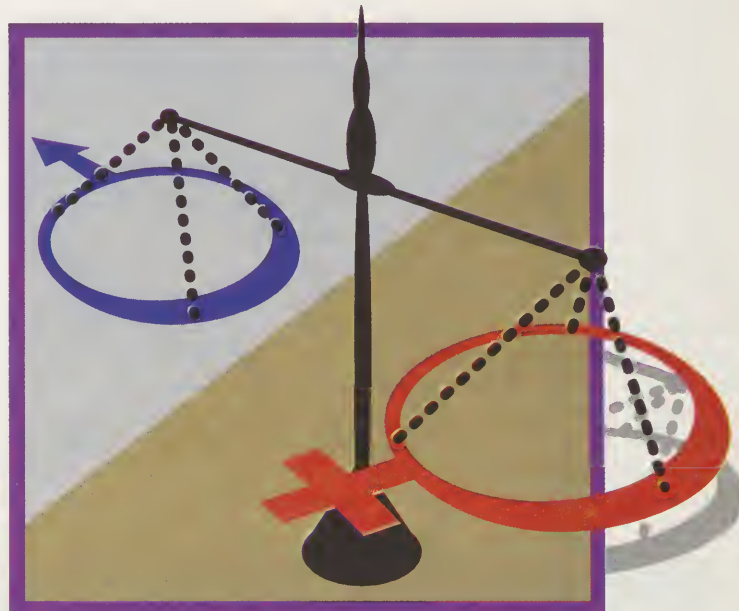
Michael Warnick, an attorney at Fedota, Childers & Rocca in Chicago, recom-

mended physician employers use U.S. Equal Employment Opportunity Commission standards as a guide when formulating their sexual harassment policies. Litigated cases often hinge on defining if the incident constitutes sexual harassment, Warnick said, adding, “It’s a nebulous area, so it’s essential to have protocols in place.”

He further stated that there must be a clear chain of command for reporting sexual harassment incidents, underscoring the importance of giving employees more than one reporting contact option in case the person harassing them is their superior. Experts agree at least one of these contact options must be a female.

There also should be a protocol for colleagues of the accuser to report what they have witnessed.

At Elmhurst Clinic, employees may go either to their immediate supervisor or to the human resources director. Once a complaint is filed, an investigation must be prompt, Dr. Brown said. The employer should discuss the complaint in detail with the complainant, and, if possible, interview witnesses. Next, the



accused party is notified of the complaint and asked for a response. They are warned that retribution or harassment toward the complainant is grounds for immediate dismissal from the clinic.

Both Dr. Brown and Warnick emphasized that the investigation must be fair and thorough. To automatically fire an employee because of sexual harassment allegations could lead to a wrongful termination charge. Such a

scenario occurred when a Miller Brewing Co. executive was fired for describing a television sitcom episode to a colleague, who found the plot offensive. The executive was later awarded \$26.6 million for wrongful termination.

“I’m sure the people at Miller felt that they were acting swiftly and decisively,” said Warnick. “But when dealing with sexual harassment, an employer must always proceed carefully.” ■

Exploding the myths of sexual harassment

Despite many misconceptions, the circumstances surrounding sexual harassment are myriad:

- Victims as well as perpetrators can be male or female
- Victims do not have to be of the opposite sex
- Harassers can be supervisors, coworkers and even nonemployees
- Victims do not have to be directly harassed, only affected by offensive conduct
- Sexual harassment can occur without economic injury and without loss of employment to the victim

Sexual harassment, as defined by the U.S. Equal Employment Opportunity Commission, consists of unwelcome sexual advances, requests for sexual favors, and verbal or physical sexual conduct that interferes with an individual’s work performance, or creates an intimidating, hostile or offensive work environment.

Employers cannot hope sexual harassment will never happen and they must take steps to prevent it. Clearly communicate to employees that harassment will not be tolerated, establish an effective grievance process, and take immediate and appropriate action should an employee make a complaint.

ISMIE earns rate hike from Standard & Poor’s

In the midst of a health care environment enduring dramatic variations in practice and policy, the financial strength of ISMIE remains solid and strong. This assessment came courtesy of Standard & Poor’s, the renowned fiscal analysis agency, which recently awarded ISMIE an updated insurer rating of BBB (positive). Previously ISMIE’s assigned rating had been BBB (stable).

Standard & Poor’s credited ISMIE’s physician-run, physician-owned carrier stance as forging a leading presence in the Illinois medical malpractice market. The report also cited ISMIE’s strong business position in its chosen niche, superior capitalization and an operating performance that has improved by 10.8 percent and 15.5 percent,

respectively, over the last two years as contributing to the new rating.

The agency further said it believed a recent increase in ISMIE’s product offerings helped it firmly establish itself as a full-service medical liability provider. Among those new products were a managed care stop-loss policy to protect against capitation risk, an employment practices liability policy and higher limits up to \$10 million.

The rating hike confirms that—according to Standard & Poor’s—“ISMIE’s long-term strategy of putting the physician first, and using service and price stability as a differentiating factor served to establish ISMIE’s current market leadership position.” ■

Carved in stone no more?

Illinois medical schools resculpt physician education in the shifting world of managed care.

BY JEFF BLACK



When asked how he created beautiful statues from blank blocks of stone, an artist replied, "Just chip away everything that isn't a statue. The trick is knowing beforehand what you're eventually going to need."

With some variation, this could be the response of Illinois' seven medical schools if asked how they intend to shape the state's next generation of physicians — just chip away everything that isn't a doctor. The "trick" in this case may be even more difficult: deciding in advance what knowledge physicians will need to remain productive and flexible in a continually shifting health care landscape, one now dominated by managed care.

It will be no easy task. Some say medical schools have historically been slow to change on any front, especially in curriculum, where shifts have been glacially paced. Complicating matters, modifications cannot be carved in stone, in anticipation of yet more change wrought by managed care.

"There is no question managed care is changing medical schools," stated Joan Cummings, MD, chairman of ISMS' Council on Education and Health Workforce, who added that in many ways outpatient clinics — at the heart of managed care — are now setting the agenda of medical education. "Medical schools are just starting to recognize the challenges they face."

However, Dr. Cummings disagreed that those schools have been slow to change in the past. They've been evolving from the very beginning, she said — and they will continue to evolve. "The big story would be that they aren't changing, not that they are."

But how are Illinois medical schools changing? How are they responding to the vagaries and vicissitudes of managed care? And how do they — the sculptors — shape able, adaptable physicians for tomorrow when health care issues remain so unclear today?

There is growing evidence that the state's medical schools are indeed changing. At the University of Illinois at Chicago College of Medicine, the evolving curriculum now includes Longitudinal Primary Care, as well as Essentials of Clinical Medicine. In the former, preceptors are typically physicians in the managed care field, and in the latter — a two-year course of study — students cover a number of primary care issues, including taking medical histories and giving physicals, skills vital to outpatient treatment.

The curriculum at the Southern Illinois University School of Medicine in Springfield is markedly different today than it was just three years ago. In a student's senior year of study, he or she now goes through six days dedicated to "The Physician and Society." After a general overview of the U.S. health care system and its financing, students move to more specific subjects, such as the impact of managed care on physician and hospital decision making, incentive structures, peer reviews, and clinical decisions and health care costs.

Erik Constance, MD, associate dean of student affairs at SIU, said that in the last 10 years he's noticed an increase in teaching "business" in medical schools. In the age of managed care, he said, that is probably wise. "Let's face it," he stated, "unlike many graduates in the past, most of these students will never have private practices. They'll be working for someone else's business and they need to know how well that business is being run."

Finch University of Health Sciences/The Chicago Medical School, in North Chicago, embodies one of the most dramatic changes in Illinois medical education.

(Continued on page 8)



Carved in stone

(Continued from page 7)

In 1995, it began a "strategic alliance" with Henry Ford Health Systems of Detroit, allowing The Chicago Medical School students – through the Primary Care Physician Initiative – to get practical, hands-on experience with a health plan heavily weighted toward outpatient clinics and managed care.

Theodore Booden, dean of The Chicago Medical School, said they were compelled to go out of state to make the alliance because the number of Illinois teaching hospitals is shrinking rapidly – a direct result, he said, of managed care and its reimbursement policies. Unlike many Illinois medical schools, The Chicago Medical School does not own a hospital; to serve its students, it had to develop other opportunities.

The initiative, Booden explained, creates a totally integrated way of learning. "Instead of traditional, knowledge-based education, our hands-on approach allows students to learn primary care. It is flexible enough, how-

ever, for students also to pursue surgery, psychiatry, or other specialties."

What can tomorrow's Illinois physicians expect from the job market once medical school and residency are over – and are they truly prepared for what they will encounter? In one area, it depends on who is talking.

Today's medical school graduates face a dramatically reduced need for specialists, according to Michael Sachs, chairman of Sachs Group, an Evanston-based health care information firm. He said that the national need for specialty physicians will plummet 19.3 percent (meaning the loss of 37,350 positions) during the five-year period ending in 2000 – even as the total need for physicians increases just under one percent. In the Midwest, the need for specialists will tumble 23.6 percent.

Sachs does not believe medical schools should discourage would-be specialists. "However," he stated, "they do need to say, 'If you're going to specialize, here is the economic reality of your decision. And here's how you need to practice as a specialist in managed care.'"

"Specialty students must ask themselves: 'When I finish training, where am I going?' They may be desirable to established medical practices for what basically are lower-compensation, salaried positions. There may still be specialist work to be had," Sachs concluded, "but under different circumstances."

At the University of Illinois at Chicago College of Medicine, associate dean and director of admissions Jorge Girotti – who is also director of the school's Urban Health Program – says more of his students are going into primary care. In fact, the school is building a huge facility to accommodate all of its ambulatory care clinics. The 245,000-square foot outpatient care center is slated to open in Chicago in July 1999.

For the future of U.S. health care, only one thing is certain: more change. Girotti won't predict what that future holds for medical schools. "It's hard to pinpoint the trends," he said. "Our aim is to train generalist physicians, students who will be ready to take any next step, be it primary care, pediatrics or orthopedic surgery."

SIU's Dr. Constance believes medical

schools must become increasingly responsive to changes in the health care system. "The marketplace will ultimately determine how many medical schools survive. Those not producing physicians effective in today's environment won't be around too long."

Yet he remains upbeat about the number and quality of medical school applicants. "With everything happening, with reduced reimbursement and managed care rules, we are not seeing a falloff in applications," he said, adding that applicants have an inherent understanding of health care today. Most grew up as patients in managed care plans. "They have the same frustrations as other patients. They know what they're getting into."

In schools statewide, the sculpting of future physicians continues – producing, out of necessity, more pliable practitioners than those allowed by the stone-set medical environment of not so long ago. With one eye on their work, and one looking out for managed care's next move, Illinois' medical schools are ready for the challenge. ■

...out like a lion

(Continued from page 1)

there were no processing delays related to the employee misconduct that led to a \$144 million government settlement. Funds used to pay the penalty will come from company reserves – not operational revenues – making no demands on provider reimbursements, he said.

The settlement announced last month stems from a three-year investigation of allegations that some employees in the Marion office from roughly 1983 through 1995 circumvented required procedures to monitor claims for accuracy and fraud. Seven employees are alleged responsible, Dr. Korn said. "What's unfortunate is that a few employees created a terrible situation," he said. "That doesn't excuse us. It happened on our watch." A new management team is in place at the center now being run by the new carrier.

The scandal played a "significant role" in HCSC's decision to drop its Illinois and Michigan claim processing, Dr. Korn said. He said HCSC made no mention of the scandal when it announced last year it was dropping the Illinois Medicare contract because the matter was precipitated by a lawsuit filed under seal. It would have been illegal to speak of it until it was unsealed in July.

Blue Cross Blue Shield plans to continue business in the public sector and is eager to get the Marion scandal behind it, Dr. Korn said.

In like a lamb...

(Continued from page 1)

Administration, Medicare's overseer. He said physicians will contact the carrier with the same phone numbers and addresses, and will talk to the same people they have been talking to at outgoing carrier Health Care Services Corp., which also does business as Blue Cross Blue Shield of Illinois. Beilfuss conceded that such a big changeover "will likely experience some glitches," though HCFA is committed to a smooth transition.

Despite HCFA optimism, the numbers alone have raised concerns. The WPS workload is expected to multiply from the 12 million claims it handled annually as Wisconsin's Medicare carrier, to more than 62 million annual claims as it expands into Illinois and Michigan. WPS is now the nation's largest Medicare Part B carrier.

"Physicians need direct communication from WPS about the change," said Herb Sohn, MD, a member of the Medi-

care carrier advisory committee in Illinois. Physicians received only one letter announcing the transition, he said. "We need information in black and white. They must explain all changes they intend to implement."

A major question is whether electronic claim submissions will be interrupted. Beilfuss said no, explaining that a deal was struck to continue using HCSC to temporarily collect claims that will be passed to WPS. The HCFA-funded arrangement will last a maximum one year or until the WPS electronic transmission system is operating. The new carrier will train physicians on the EDI process when it is ready to directly receive claims, he said.

Physicians are also concerned that new-physician certification could be slow. WPS inherited a six-week enrollment backlog, said Renee Jackson, manager of education and outreach at the Madison-based company. Additional staff has been added, and she estimates the certification process will return to the normal 30- to 45-day turnaround by September.

HCSC announced in December it was ending its Part A and Part B Medicare contract to concentrate on other business interests. It was revealed last month that an overriding factor in the withdrawal had been the alleged misconduct of some employees at the Marion center, leading to a \$144 million government settlement. (See related story.)

Information about the transition has been communicated to physicians primarily through the HCSC monthly newsletter, which has included WPS articles since April, Jackson said.

Medicare Part B medical director Douglas Busby, MD, recently resigned, leaving the position vacant. HCFA and WPS have indicated that hiring medical directors for each of the states covered by this contract is a high priority.

Members of the local carrier advisory committee and ISMS' Third Party Payment Processes Committee are concerned that an Illinois-specific medical director be in place quickly so Medicare policies effecting Illinois physicians are truly established and developed locally.

Physicians interested in the position should call WPS, (608) 221-4711, or ISMS' division of health care finance, (800) 782-4767. Physicians experiencing claim problems are also urged to call ISMS. ■

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Rights fight

(Continued from page 1)

that if held accountable, HMOs would make the right decision in the first place."

The ISMS contingent also disagreed with having medical malpractice caps included in the GOP plan — a move they maintain will poison any bill.

"Tort reform is near and dear to our hearts," Dr. Geline said, "but President Clinton has said he will veto a patient rights bill if it includes caps."

"A bill is of no value to the American

*... if held accountable,
HMOs would make
the right decision in
the first place.*

people. We need a law," Dr. Sprang said, adding that keeping the two battles separate increases the chances a patient

rights bill will become law. Hastert's spokesman denied that including caps in the GOP reform bill was an attempt to kill its chances.

Reps. Greg Ganske (R-Iowa) and John Dingell (D-Mich.), and Sen. Tom Daschle (D-S.D.) sponsored a stronger patient rights bill supported by the AMA and ISMS. This bill, erasing the ERISA exemption, was defeated July 24.

Dr. Callan said congressmen predicted progress this year. "Everybody said they would pass something," she said. "That something is still up in the air."

HCFA releases rules

(Continued from page 1)

nation of patient records and track the results of disease treatments. Release of the patient-ID rule is expected soon.

Already released rules create two items key to simplification: a standard format for electronic health care transactions and a universal provider-ID number. "The change will require some work, but in the long run could benefit everyone if properly applied," said Richard Snodgrass, MD, chairman of ISMS' Third Party Payment Processes Committee.

An ISMS analysis deemed standardized transactions include health claims and their status, coordination of benefits, and premium payments, among others.

How physicians bring their offices into compliance depends on their existing computer system, said John Lumpkin, MD, director of the Illinois Department of Public Health and a member of the National Committee on Vital and Health Statistics, which oversees the U.S. Department of Health and Human Services' administrative simplification effort. Some physicians may need only upgrade their current systems; others may have to buy a new system to comply.

Despite initial hassle, some say the benefits of compliance are considerable. "Physicians and staff will spend less time on administrative activity and more time on patient care," said Jim Schuping, executive vice president of the Workgroup for Electronic Data Interchange, a national organization working to increase the usage of electronic transactions. ISMS is a WEDI member.

Physicians who haven't computerized their offices should consider it, Schuping said. Filing paper claims may become increasingly expensive as the industry moves toward a standard electronic transaction process.

Clearinghouses (companies paid by physicians to submit claims), providers and large health plans must be in compliance no more than 24 months after the rule's adoption. Small health plans have 36 months to comply. Final action on the rule is expected later this year.

A second pending rule requires each provider, including physicians, to be assigned an eight-digit alphanumeric number. Insurance companies will use it to process transactions. Currently, physicians and other providers receive different identification numbers from private health plans, Medicare and Medicaid. HCFA said multiple physician numbers are easily confused, slow bill payment and increase costs.

Dr. Snodgrass said that as simplification procedures are created, care must be exercised so that data necessary to process claims and other transactions are not inappropriately applied.

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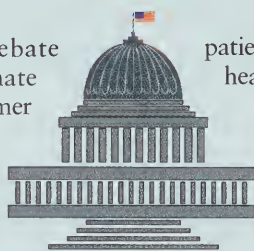
PAGE 3

Physicians press for overhaul of House-approved bill



Dr. Geline maintains that H.R. 4250 still requires substantial modification and additional patient protections. "One key stumbling block," he says, "is health plan accountability."

The simmering patient rights debate could reignite when the U.S. Senate returns in September from its summer break. In the interim, however, organized medicine is making good use of the time, circulating a list of the top 10 problems it has with a House-approved patient rights bill.



ISMS members can find the American Medical Association-generated list between pages two and three of this issue of Illinois Medicine. It will be useful to concerned, grass-roots physicians when contacting their legislators.

The bill in question, H.R. 4250, or the Patient Protection Act, was crafted by the GOP's Working Group on Health Care Quality. On a 216-210 vote, it passed the House on July 24, moving to the Senate for further debate. U.S. Rep. J. Dennis Hastert (R-Ill.), the working group's chairman, said, "Our legislation is the only proposal on the table that truly protects

patients and guarantees choices without the heavy hand of big government."

ISMS President Richard Geline, MD, disagreed, saying the House bill still requires substantial modification if it is to provide patient protections strong enough to make a difference in health care delivery. "One key stumbling block is health

plan accountability," said Dr. Geline.

The AMA, ISMS and other medical societies prefer S.1890, a patient-rights bill sponsored by Sen. Thomas Daschle (D-S.D.), which includes several reforms missing from the House-approved legislation. A House version of Daschle's bill was narrowly rejected in July.

"Real progress has been made since we began advocating patient rights legislation," said Thomas Reardon, MD, the AMA's president-elect. "What we need now is a bipartisan solution that puts patients first."



Rep. Hastert says the House-approved bill "is the only proposal . . . that truly protects patients and guarantees choices without the heavy hand of big government."

Feds set PSO rules

HEALTH PLANS:

Physicians get
HMO bypass

BY JANE ZENTMYER

[WASHINGTON] When Congress included provider-sponsored organizations in last year's Balanced Budget Act, physicians were given the chance to compete for Medicare managed care contracts by forming their own PSOs. Now, with the federal regulations issued, physicians can begin to weigh a PSO's benefits and risks to decide if creating one is worth the effort.

However, time is of the essence, cautioned Anne Murphy, a partner and head of the health law practice at Vedder, Price, Kaufman & Kammholz in Chicago. "Others are out there already expanding into the Medicare managed care marketplace. The more time that goes by, the more difficult it's going to be for another play-

(Continued on page 10)

HCFA moves on Medicare+Choice plans

INSURANCE: Consumer protections built into managed care options. BY JANE ZENTMYER

[WASHINGTON] Even as Congress fought over managed care reform, the U.S. Health Care Financing Administration pushed ahead with plans to incorporate consumer protections into Medicare's managed care plans.

A HCFA rule that became effective July 27 detailed how the agency plans to house all of Medicare's managed care offerings in Medicare+Choice, a new program created by the Balanced Budget Act of 1997. To comply with a presidential order, HCFA also added patient protections to its managed care plans.

According to an ISMS analysis, the following consumer protections are among many included in Medicare+Choice:

- Women have direct access to a women's health specialist—within the plan's network—who can provide routine and preventive health care services

- Patients with complex or serious medical conditions must be given an adequate

number of direct-access visits to specialists in accordance with their treatment plan, which should be time-specific and updated periodically by their primary care physicians.

- Emergency-service coverage must be provided if patients

possessing an average knowledge of medicine expected the absence of immediate attention to jeopardize their health.

- Managed care plans cannot prohibit or restrict physicians from advocating on their patients' behalf, or advising them about their health status or treatment options.

Patient protections must be included in all plans offered by Medicare+Choice organizations. These organizations are defined as public or private entities licensed by a state as a risk-bearing entity, and certified by HCFA as meeting certain contract requirements. Health maintenance organizations or preferred provider organizations meet these conditions.

Another insurance option available to Medicare patients is a medical savings account, which pairs a high-deductible insurance policy with a savings account. In the Medicare MSA, HCFA will contribute to the savings account, and any earnings on the monies will grow tax-free. Patients use the account to pay for care until they reach their deductible—then the insurer pays the bills.

"Medicare+Choice offers beneficiaries insurance options that broaden the ways they can receive health care," said Nancy-Ann Min DeParle, administrator of the U.S. Health Care Financing Administration. "But if beneficiaries are happy with the way they get their

(Continued on page 8)

INSIDE

**Weighing diet pill
prescriptions**

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AMA settles Sunbeam lawsuit

In what it hopes is the final chapter of a damaging saga, the American Medical Association announced a settlement with Sunbeam Corp. in a breach-of-contract suit stemming from a doomed product-endorsement deal. The agreement was announced almost exactly one year after news of the deal became public.

According to a July 31 statement, the AMA agreed to reimburse Sunbeam \$2 million for out-of-pocket expenses, including attorney fees, as mandated by

the original contract. The AMA will also compensate Sunbeam \$7.9 million in damages. Sunbeam had sought \$20 million in its initial suit.

On Aug. 12, 1997, the AMA announced a five-year product-endorsement arrangement with Sunbeam in which the organization's logo would appear on selected Sunbeam products. Ten days later, in the face of harsh criticism, the AMA board withdrew from the agreement, prompting Sunbeam to file its lawsuit. By year's end, several AMA executives had resigned or were terminated amid the fallout.

In making the nearly \$10 million settlement public, AMA board chairman Randolph Smoak, Jr., MD, said, "Our agreement resolves all outstanding differences between our organizations. The AMA is now fully focused on its historic mission to serve America's patients and the quality of American medicine." ■

Women's health grants available through IDPH

The Illinois Department of Public Health has announced the availability of funds for women's health programs and research.

General Women's Health Initiative Grants and Osteoporosis Awareness Grants are administered by the IDPH's Office of Women's Health. The General Women's Health Initiative Grants are available to support outreach, professional education, screening and behavior modification activities designed to address the special health needs of women and girls. The Osteoporosis Grants will fund 35 to 40 professional and public osteoporosis-education programs.

Eligible applicants include local health departments, not-for-profits and community agencies. Applications for these grants are due Sept. 9, 1998.

The OWH also administers the Illinois Breast and Cervical Cancer Research Fund, from which grants are now also available. This fund is intended to support research into the prevention, etiology, pathogenesis, early treatment and behavioral science of breast and cervical cancer. Fund applications will be available after Sept. 15, 1998.

"We're pleased to offer these sources of funding," said OWH Deputy Director Sharon Green, "and know they'll help elevate the importance of women's health issues across the state."

For more information about the women's health grants, or to receive applications, contact the OWH at (217) 524-6088. ■

Dr. Mohyuddin receives SIU-E service award

Sadiq Mohyuddin, MD, a Godfrey physician, won the Kimmel Community Award in recognition of his outstanding service and dedication to his community. The award was presented by Southern Illinois University-Edwardsville and the Belleville News-Democrat.

Specializing in internal medicine and pulmonary disease in the Alton and Godfrey area for more than 27 years, Dr. Mohyuddin is on the staffs of Alton Memorial Hospital, St. Anthony's Medical Center and St. Clare Hospital. He is also a member of the faculty of St. Louis University School of Medicine.



Dr. Mohyuddin



150 YEARS OF CARING. Honoring Peoria Medical Society's sesquicentennial, ISMS at its annual meeting presented the organization with a copy of a photo from a 19th century ISMS meeting held in Peoria. Left to right: Chester Danehower, Jr., MD, former ISMS secretary-treasurer; Rodney Osborn, MD, president, Peoria Medical Society; M. LeRoy Sprang, MD, immediate-past chairman, ISMS Board of Trustees; and M. John Hanni, Jr., executive vice president, Peoria Medical Society.

Dr. Mohyuddin served as president of the Madison County Medical Society in 1984 and has been elected for 12 terms as a delegate to the ISMS House. This spring, he was named president-elect of the World Affairs Council of St. Louis, a nonpartisan organization that promotes international education and understanding of political, economic, business and cultural events.

In addition, he recently established a charitable clinic in Lahore, Pakistan, which provides free medical treatment, medicine and immunizations for the indigent population there. He has also worked to raise awareness of human rights violations in the region of Kashmir.

"I believe personal involvement and hands-on efforts help me develop a one-on-one relationship with humanity," Dr. Mohyuddin said. "What little I do may

seem more symbolic than anything else, but I believe I can create an example for others, stimulating them to do the same." ■

"Unusual" bacterium raises Lyme disease concern in Cook County

Chicago-area health officials are uncertain if an "unusual" strain of bacterium found in some area rodents poses a risk of Lyme disease transmission via ticks to humans. No one in Cook County has yet been found carrying the disease-bearing strain – but they urged public vigilance.

Because a mild winter created a surge in the tick population, officials said Chicago-area physicians should urge patients to take precautions to avoid tick bites: Wear protective clothing; use insect repellents; inspect pets for ticks before bringing them indoors.

Early symptoms include skin rash, fatigue, headaches, pain or stiffness in muscles, neck and joints, jaw discomfort, fever and swollen glands.

Initially, the disease can be misdiagnosed as the flu. Detected early, it is readily treated by antibiotics; untreated, it can eventually lead to heart, nervous system or joint problems. ■

Detectives appeal to area physicians for leads in abandoned baby case

Police in Mount Prospect, a suburban community northwest of Chicago, are asking Illinois physicians for help in finding the parents of an abandoned baby.

The five-pound, 13-ounce boy was found at 12:30 a.m. on July 6. The sus-

pect, believed to be the baby's mother, is a white female approximately 5'10" tall, with long blonde hair. Detectives estimate her age at between 23 and 25.

A Mount Prospect resident witnessed a woman matching that description place a bundle in the bushes of a residential yard near Rand and Elmhurst Roads; the resident subsequently discovered the abandoned newborn within the bundle. The suspect was driving a white and dark-brown Ford Explorer, and was wearing a striped tank-top shirt and khaki shorts.

Mount Prospect detective Bob Riordan is asking area physicians to look for a female patient matching the above description who might have sought care either before or after the birth.

Anyone with information should contact Detective Riordan concerning this case at (847) 870-5654. ■

Research Money, and Where It Goes

The National Academy of Sciences urged the National Institutes of Health to consider factors like death rates in allocating research money on various diseases.

DISEASE OR CONDITION	NUMBER OF DEATHS (1996)	N.I.H. SPENDING PER DEATH
H.I.V. infection and AIDS	32,655	\$43,206
Kidney and urologic diseases	24,392	\$13,414
Chronic liver disease and cirrhosis	25,135	\$6,756
Diabetes	61,559	\$4,856
Cancer	544,278	\$4,723
Heart disease	733,834	\$1,160
Pneumonia and influenza	82,579	\$750
Chronic obstructive pulmonary disease and allied conditions	106,146	\$588
Septicemia	21,395	\$509

Sources: National Academy of Sciences, National Institutes of Health

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Court creates new roadblock in defending medical malpractice suits

DECISION: Independent-contractor physicians at heart of "apparent agency" ruling. BY JANE ZENTMYER

Physicians, hospitals and other providers do what they can to prevent malpractice lawsuits and avoid a whirlwind ride through the state's legal system. But getting sucked into a lawsuit as a defendant just got more likely because of an Illinois appellate court's decision released earlier this year.

The decision involved a legal doctrine known as "apparent agency," which holds entities responsible for the actions of individuals who can be considered as acting on the entity's behalf. Under this doctrine, for example, hospitals could be held liable for the actions of independent-contractor physicians.

As ISMS General Counsel Saul Morse put it, "If physicians imply they have authority to do something, and a hospital or similar entity doesn't say to people 'no, they're not acting on our behalf,' then that hospital or entity has to accept responsibility for what the physicians apparently were authorized to do."

"This puts a large ribbon around all potential defendants," said E. Michael Kelly, a partner at Hinshaw & Culbertson in Chicago. "The doctrine enables plaintiff attorneys to add defendants, especially those with deeper pockets," he said. "They want a wide net so they've

got a lot of pockets to reach for. The more pockets they have, and the deeper they are, the happier plaintiffs [and their attorneys] are."

A 1993 Illinois Supreme Court decision began the expansion of the apparent agency doctrine in Illinois. In its decision, justices ruled hospitals could be held liable for the actions of emergency physicians who were independent contractors. In March of this year, the 1st District Appellate Court expanded the doctrine by applying it to independent-contractor physicians who work outside emergency rooms.

The ruling stems from a case filed by Edgardo and Ruby Dahan against now-defunct Mount Sinai-North Hospital, which operated as a joint venture of UHS of Bethesda Inc. and Mount Sinai Medical Center. An ophthalmologist referred Edgardo Dahan, a hospital employee, to Charles Schikman, MD, after Dahan

complained of vision problems possibly related to migraine headaches.

Dr. Schikman, director of the hospital's diabetes clinic, had a contract with Mount Sinai to provide medical care to hospital

patients who visited the clinic and to provide care at no cost to hospital employees hurt on the job.

Dahan saw Dr. Schikman twice at his hospital office. During the second visit, Dahan said his migraines were better, but his vision had worsened. Dr. Schikman ordered a carotid ultrasound examination and instructed Dahan to return in two weeks.

Before his follow-up visit, the then-29-year-old patient had a stroke that left him partially paralyzed. A lawsuit alleged that Dahan would not have suffered the stroke if the physician had properly diagnosed his condition as polycythemia rubra vera. A jury returned an \$11.9 million verdict against Dr. Schikman and the hospital.

The doctrine enables plaintiff attorneys to add defendants, especially those with deeper pockets.

On appeal, the hospital argued that Dr. Schikman was not an employee of the hospital. The appellate justices ruled, however, that the patient could not have known that the physician was an independent contractor; the apparent agency doctrine applied in this scenario, they said.

"Twenty years ago a hospital, clinic or group would [use the defense] that somebody was not their employee or agent. The burden was on the plaintiff to establish there was some employment relationship or control," Kelly said. "Now, to defeat apparent agency, [the defense] has to show there was a clear reason for the plaintiff/patient to know the doctor was not an agent."

The expansion of the apparent agency doctrine could increase tension between physicians and hospitals. "If the hospital feels it's going to be responsible for doctors anyway, it will exert more control over them," Morse said. "It raises the specter of doctors 'forced' to work for the hospital."

Additional questions for physicians arise out of this most recent expansion. "If a doctor refers a patient to another physician, is the subsequent specialist the apparent agent of the referring doctor?" Kelly asked. "If you, as a specialist, send a Pap smear to a lab and they blow the diagnosis, are they your apparent agent in addition to being a defendant themselves?"

Despite this new roadblock to defending malpractice lawsuits, "I tell doctors we win most of the time," Kelly said. "The amazing thing is that we do win, because the deck is clearly stacked against us." ■

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EDITORIAL

Accept no cheap imitations

It would probably be easier to find a Congressman lunching with Saddam Hussein than to discover one opposed to a patient bill of rights. Politicians at last have read the American public's disenchantment with managed care plans and have brought to Congress a bundle of reform proposals to build a better system.

But talking the reform talk and getting real reform to walk are two different tasks. At first glance, most plans appear pretty much alike. They have similar Bill-of-Rights titles and address the same issues, such as gag clauses, emergency room coverage and plan information disclosure.

However, physicians beware: Not all patient rights proposals are the same! Slip them under a microscope, and the fine print reveals differences of monumental proportions.

Physicians, led by organized medicine, are playing a lead role in advocating patient rights in the battle currently being played out in Washington, D.C. And what physicians are saying is that many important measures are missing or deficient in the House Republican task force's Patient Protection Act of 1998, H.R. 4250.

As it stands now, the GOP version is a smoke screen to convince voters their elected leaders are coming to the rescue, saving them from managed care shortcomings. But, when the smoke clears, the language left protects managed care business interests instead, with loopholes that allow them to escape delivering the coverage, care and accountability patients deserve.

Now is the time to hammer home to Congressional representatives details that will form a solid foundation for physician-driven health care decisions:

- Defining medical necessity should be in the hands of physicians and patients, not HMO business executives.

- Patients should not be charged a fee to have their grievances heard by a neutral reviewer.

- Access to emergency care must assure coverage based on the prudent layperson standard, with no prior authorization, and with no greater cost for care at an emergency room outside of the plan. In addition, a plan must assure patients of maintenance and poststabilization care so that they are not financially on the hook for expenses beyond the original emergency.

- Gag clauses should be unequivocally prohibited, without loopholes permitting communications only after the physician complies with certain restrictions.

Although the GOP Patient Protection Act passed the House in July, it is by no means the final word. The Senate debate slated to occur this fall, followed by a House-Senate conference, opens the door for improvement.

Physicians must not be fooled by a cheap imitation of patient rights that lacks the strength to withstand the open market. It's imperative that Congress not hand the American people a pleasant-looking facade that caves in when patients try to use it.

PRESIDENT'S LETTER

The HMOs' new best friend: Why H.R. 4250 is unacceptable

Richard A. Geline, MD



"The bill misses few, if any, opportunities to favor insurance companies."

The managed care experiment seems ready to take a step. Will it be a long, meaningful, necessary stride toward patient protection and good medical practice, or a minimal stutter-step that essentially changes nothing and, perhaps, sends us in the wrong direction?

The debate centers on patient-protection legislation presently before Congress. The Patients' Bill of Rights (H.R. 3605/S. 1890), which I discussed here last time, offers real, tangible reforms to curb the excesses of managed care. It allows free and unrestricted discussions between doctors and patients, guarantees patients get the full truth from their health plans, provides the right to appeal health plan decisions, assures emergency services are authorized when patients need them, and, most importantly, holds health plans accountable for their actions.

Only after feeling intense public pressure did the House Republican majority leadership respond with its own bill, H.R. 4250. By the narrowest of margins, on a practically solid party-line vote, this weaker, ultimately unacceptable bill was adopted by the House.

Never has the phrase "the devil is in the details" rung more true than when applied to this bill. It was presented as a sound alternative offering incremental change; that description stretches the elasticity of the English language to its maximum.

The HMOs' new best friend, H.R. 4250 misses few, if any, opportunities to favor insurance companies at the expense of patients. It actually authorizes some plans to override hard-won reforms already in place at the state level, and would make it harder for states to pass reforms in the future. And, unbelievably, it gives plans, not treating physicians, the power to determine medical necessity. By retaining that power – "a health plan's smart bomb capability," according to one former HMO medical director – the plan retains control of health care decision-making.

H.R. 4250 requires the patient to *pay* to have cases heard by a neutral reviewer, certainly a powerful deterrent to people of modest means. The bill also fails to assure continuity of care for patients in the midst of serious illness or pregnancy; nor does it provide chronically ill patients needed access to specialty care. It makes it much too easy for plans to deny patients a point-of-service option. Choice of physician is critical to assuring quality care. And the few reforms H.R. 4250 does offer would be delayed by up to two years. Patients need protection now.

Most importantly, however, H.R. 4250 fails to make insurance companies responsible for their actions by closing the liability loophole granted them by the Employee Retirement Income Security Act of 1974. Without accountability, plans will have no motivation to change their behavior.

The matter now moves across the Capitol rotunda to the Senate, where it will sit at least until the end of the summer recess. Senators left town without taking action, unable to agree on a rule for debating the competing versions of managed care reform.

What will ultimately emerge remains in doubt. There may be a strong bill, a weak bill, a bill inviting a presidential veto, or perhaps no bill at all – the same disappointing result that emerged from the Illinois General Assembly last spring.

Whatever happens, several factors remain abundantly clear:

First, the need for meaningful reform is becoming increasingly acute. Second, the public is not just ready for managed care reform, but desires and demands it. Finally, organized medicine owes it to our patients and profession to continue the fight – in Springfield and in Washington – for as long as necessary to make patient rights a reality. There is no alternative.

Make your legislators understand this. Make sure they know you'll be watching what they do.

GUEST EDITORIAL

Holding HMOs accountable for their egregious conduct

By Jamie Court

For years, HMOs have played hide-and-seek with the law. HMOs overturn doctors' decisions, deny treatment and then claim in court that they don't practice medicine, only provide coverage, so that HMOs cannot be sued for medical malpractice. When patients dispute coverage denials, HMOs too often duck behind the curtain of binding arbitration to avoid juries.

If an employee tries to take an HMO to court, the HMO hides behind a loophole in federal law governing employee-employer benefits, the Employee Retirement Income Security Act. The companies claim they cannot be held accountable to state laws or in state courts where damages are available. (HMOs that lose the federal grievance only pay the cost of the procedure they denied, not other damages or penalties.)

The ERISA law must be changed to conform with the realities of the modern, for-profit managed care system – HMOs are notorious for putting money ahead of good medicine, but can they injure with impunity because of ERISA's shield of immunity? No matter how egregious their conduct, HMOs administering employer-paid health care never pay damages to the patients they wrong.

Debra Moran's managed care ERISA nightmare began in July of 1995 when she developed pain in her hand, wrist, elbow, shoulder and neck. The pain came from two related conditions that impair circulation and neural transmission. As the conditions worsened, the pain grew. The Winfield, Ill., woman could not cook, clean, go to work or feed herself. According to Moran, she continued to get the run-around from her HMO, which refused to refer her to

the right specialists and, ultimately, denied coverage for the surgery that even the primary care physician at her HMO deemed necessary.

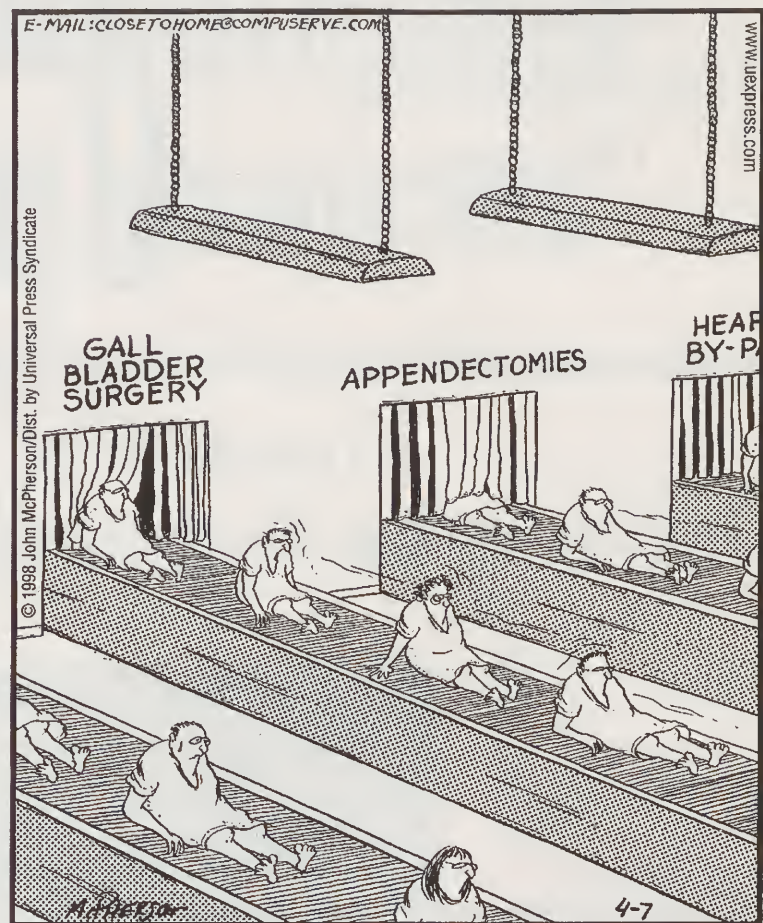
Moran was forced to find out about her condition herself – through research and an out-of-pocket evaluation by a specialist in Virginia. The specialist recommended surgery to repair the nerve and restore circulation. Unfortunately, Moran's HMO denied payment for this \$110,000 procedure, claiming it was not medically necessary. Under ERISA, the denial will have no consequences for the HMO. Because Moran received her health care coverage through an employer, she can never recover damages, only what the HMO should have paid in the first place. There is no cost to stonewalling. And ERISA's standard for proving an "arbitrary and capricious" denial to recover even those costs is much higher than the "medically necessary" standards under state law.

The cost of inaction on reforming ERISA is being shouldered by patients like Moran and cancer patients who die before their families can navigate ERISA's arcane grievance procedure. If a patient dies before getting his or her treatment, the HMO is liable for nothing.

Fortunately, Sen. Richard Durbin (D-Ill.) is sponsoring federal legislation to end ERISA's preemption of damages available in state courts.

The HMO industry has spent millions to scare legislators away from reforming ERISA with cries of increased health care costs, even though recent studies counter these claims. Texas, for instance, recently became the first state in the nation to offer its citizens a way around ERISA by allowing HMOs to

CLOSE TO HOME JOHN MCPHERSON



"I gotta find a new HMO."

be taken to state court for medical negligence. The HMO industry made similar arguments to deter the Texas reform – claiming a billion-dollar price tag. When an actuarial analysis of the bill's impact was performed after it was passed, the cost was estimated to be a mere 34 cents per member per month (about 0.3 percent). The Texas law became effective Sept. 1, 1997 and, according to the Republican author of the bill, at most one lawsuit has been filed under the statute.

Deterrence, not litigation, is the goal of holding HMOs to the same state-based liability other industries face. Unless there are consequences to an

HMO for denying expensive treatment, the financial calculus of "managing care" will always weigh toward withholding and delaying costly care, no matter how sorely the treatment is needed.

Genuine HMO reform efforts must create consequences for wrongdoing. Patients like Debra Moran deserve more from their HMOs and their politicians than the game of hide-and-seek that has been going on for too long at too great a toll.

Jamie Court is director of Consumers for Quality Care, a Santa Monica, Calif.-based health care watchdog group.

TIME/CNN POLL

Should the government regulate HMOs and other managed care providers in the following ways to protect consumers, or not do so because it would raise costs and increase bureaucracy?

Yes

Allow patients to select their doctor rather than have one assigned by their HMO **79%**

Pay for emergency care if the patient did not get permission in advance **72%**

Pay for treatment by specialists recommended by a primary care doctor even if the managed care provider did not approve it **70%**

Allow patients who have been denied care to appeal that decision to a neutral third party **70%**

Allow patients to sue their managed care provider for decisions made regarding their medical care **63%**

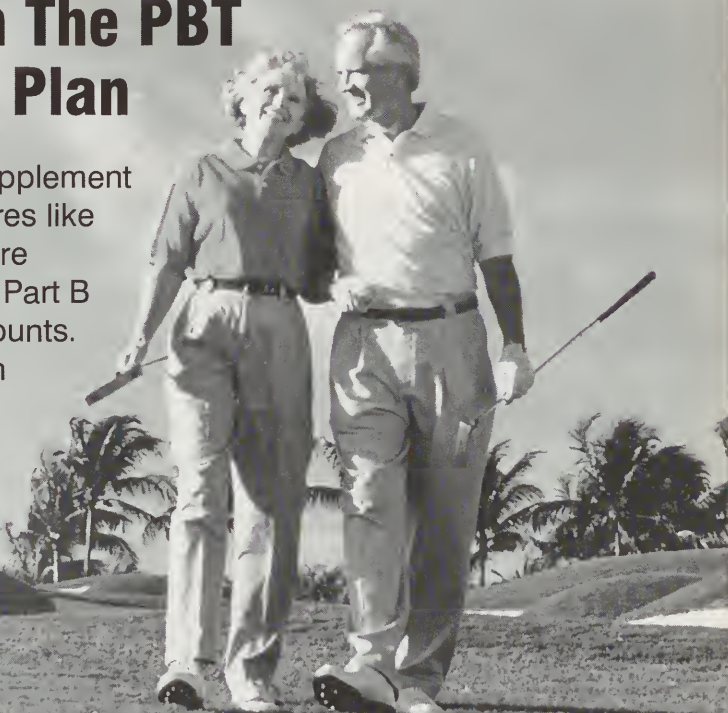
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ISMIE Update

Prescribing diet medications: Knowing the pitfalls can spare legal trouble

BY NINA BERNARDI

Since the FDA pulled the diet drug fen-phen off the market, physicians have been wary of prescribing new pills that have emerged to take its place. Patient demand, however, is keeping pressure on physicians to chance writing a risky prescription.

The latest obesity drug to capture the public's interest is Meredia, manufactured by Knoll Pharmaceutical. The Food and Drug Administration approved use of Meredia with the warning that the drug only be used for the severely obese. FDA officials also warned that some patients may experience a dangerous rise in blood pressure.

"I've never prescribed diet drugs and will not start," said Richard Snodgrass, MD, a Moline cardiovascular specialist who is also on the Risk Management Committee of the Illinois State Medical Inter-Insurance Exchange (ISMIE). "I advocate my patients cut back on their eating and exercise to the extent appropriate for their condition. It's a safer approach."

The fen-phen controversy prompted Ronald Hirsch, MD, to rule out prescribing any diet medications, including Meredia, even though patients have "practically begged" him for it. "As frustrating as obesity is, a pill that doesn't cure the disease, but only treats the symptoms is not worth risking my patients'



Illustration by John D. Ahearn/SIS

health," said Dr. Hirsch, a board-certified internist from Lake in the Hills. While the choice to prescribe or not to prescribe is often a personal one, there are several precautions physicians should keep in mind to manage risk before signing the paperwork.

Knowing the law, the physician bears the brunt of the responsibility when prescribing medication, explained Michael J. Wagner, an attorney with Baker & McKenzie in Chicago.

"Many doctors work under the misconception that the drug company is obligated to give warnings directly to the consumer for diet pills, and that's not the case for any prescription drug," Wagner said. The relevant legal principle, called the Learned Intermediary Doctrine, states that physicians must act as informed middlemen between the drug company and the patient because the physician knows the patient best.

As a result, the courts have

largely found the physician accountable when complications occur. Managing risk starts with doing some homework, and a physician's best and only defenses are education, explanation and documentation. In most states, including Illinois, the law requires pharmaceutical companies to give doctors informational materials showing drug risks, benefits, indications and contraindications. If the courts find the information inadequate, the pharmaceutical company

can be held accountable.

Still, physicians must take the time to become familiar with all drug information before judging each patient's case. They must also take the time to thoroughly explain risks and benefits to the patient and thoroughly document the conversations.

Wagner suggested that physicians make a notation in a patient's chart that "risks and benefits were explained," and list common or likely reactions to the drug. In all cases, physicians should explain the most serious possible complication. This is essential because, as Wagner explained, a patient is not likely to sue if he or she only develops a skin rash. "It's when you have the serious adverse reaction that you're likely to see a lawsuit." For these types of cases, the courts cannot award punitive damages against physicians in Illinois, Wagner said. The courts can only award compensatory damages, such as money to cover medical bills or loss of earnings.

It is therefore wise to provide patients with all available literature on the drug, said Dick Donohue, attorney with Donohue, Brown & Matthewson in Chicago. Also avoid the pitfall of giving away drug samples without the necessary patient conversation and documentation, he concluded. ■

ISMIE offers office risk management seminar

Are you a physician or medical office-staff member wanting to provide even greater quality of care? Committed to preventing patient injury? Concerned about reducing your chances of being a litigation target? According to the Illinois State Medical Inter-Insurance Exchange's Risk Management Division, an upcoming ISMIE seminar is designed especially for you.

"An Essential Office Practice" is a three-hour risk-management program specifically geared to developing and implementing effective office risk-management strategies. By the workshop's end, participants should be able to:

- ✓ Develop office procedures for medical record access and retention.
- ✓ Implement guidelines for patient follow-up.
- ✓ Summarize legalities involved in the treatment of minors.

The ISMIE-developed program costs \$15 per person. Registration and payment must be mailed to the ISMIE Risk Management Division, 20 N. Michigan Ave., Suite 700, Chicago, Ill. 60602. For information or a seminar brochure, call the Risk Management Division at (312) 782-2749 or (800) 782-4767, Ext. 1327.

"An Essential Office Practice" – which will earn participants up to three hours of Category 1 credit toward the American Medical Association's Physician's Recognition Award – has been scheduled for the following dates:

SEPT. 3	ST. CHARLES PLACE	ST. CHARLES
SEPT. 9	UNIVERSITY CLUB	CHICAGO
SEPT. 18	JUMER'S CHATEAU	BLOOMINGTON
SEPT. 24	CLOCK TOWER RESORT	ROCKFORD
OCT. 7	SHERATON NORTH SHORE HOTEL	NORTHBROOK
OCT. 15	HOLIDAY INN O'HARE	ROSEMONT
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U.S. Senate candidates provide clear choices

Republican Fitzgerald seeks to unseat incumbent Democrat Moseley-Braun

By Linda Mae Carlstone



Next in a series
profiling key
Illinois
candidates &
races.

The electorate's perennial bemoaning that candidates are all the same will likely not be heard this election season about Illinois' U.S. Senate race. Conservative Illinois Sen. Peter Fitzgerald is attempting to unseat liberal Democrat U.S. Sen. Carol Moseley-Braun in a race that promises to offer voters clear-cut candidate differences.

One place the two differ is in their stand on tort reform, which would set limits on medical malpractice lawsuits. Moseley-Braun said proposals thus far to cap medical malpractice lawsuits "go too far on

shutting the door to patients' abilities to be compensated for injuries. We need to reduce transaction costs without barring access to the courthouse," she said. "Unfortunately none of the medical malpractice proposals have even remotely reached that balance."

Fitzgerald, on the other hand, has led the fight for tort reform in the General Assembly and believes the current federal health care reform proposals might make the timing right for "Congress to seize the opportunity to get tort reform enacted."

Although the unofficial Labor Day start to the fall campaign season is still a few weeks away, there are signs this statewide race will be a contentious battle; neither side is expected to give ground when the feathers fly.

"I'm going to run a vigorous campaign against an opponent who is vulnerable on her record," Fitzgerald said. He added that Moseley-Braun's candidacy carries the burden of a relationship with the late Nigerian dictator Sani Abacha. Moseley-Braun's

opponent. "I agree there's an extremist in the race. It's Carol Moseley-Braun," said Fitzgerald, ticking off Moseley-Braun votes he said prove his point: "She voted eight times against welfare reform, to strip the middle-class tax cuts out of last year's balanced budget bill, and twice against repealing the marriage tax penalty."

Fitzgerald said he holds a centrist position on many issues that get overlooked. As an example, he offered, "I have supported the Brady Bill and the ban on assault weapons."



Ill. Sen. Peter Fitzgerald

Born: Oct. 20, 1960

Position: Ill. Senator, 27th District, elected 1992.

Committee assignments: State Government Operations; Insurance & Pensions; Revenue.

Both candidates say their records demonstrate fervor for improving the nation's health care dilemmas.

"I was a chief Senate sponsor (in the Illinois General Assembly) of the landmark 1995 tort reform legislation," Fitzgerald stated. "[I was] responsible for arguing caps on noneconomic damages and repeal of joint and several liability." Fitzgerald also voted for the managed care reform bill that passed the Senate last spring. "That legislation banned gag rules," he pointed out.

Moseley-Braun said the genesis of her health care initiatives dates back to when she worked on health care policies as assistant United States attorney under President Jimmy Carter. In Congress, she cosponsored the Health Insurance Portability Act and the Patients Bill of Rights. She has used her position on the Senate Finance Committee to advocate women's health issues, championing passage of a law for full Medicare coverage for mammograms.

Fitzgerald, 37, was elected to the Illinois Senate in 1992, the same year Moseley-Braun won her seat in the U.S. Senate. The independently wealthy Fitzgerald has worked as a corporate attorney in Chicago and was in-house general counsel for a family-run bank holding company until it was sold to a Montreal bank 1994. At present he is a full-time legislator. He lives in the northwest Chicago suburb of Inverness.

Chicago resident Moseley-Braun, 51, was the first African-American woman elected to the U.S. Senate. The daughter of a police officer, she served as an assistant U.S. attorney from 1973 to 1977. In 1978 she was elected to the Illinois House of Representatives, where she served 10 years until elected Cook County Recorder of Deeds.

U.S. Sen. Carol Moseley-Braun

Born: August 16, 1947

Position: U.S. Senator, elected 1992.

Committee assignments: Senate Finance; Banking, Housing and Urban Affairs; and the Special Committee on Aging.



former fiancé was a paid lobbyist for the Nigerian government. In 1996, she broke ranks with the Congressional Black Caucus, which favored economic sanctions against Abacha's regime.

Moseley-Braun, too, appears ready for a fight. "Sneaky" is how she described her opponent, adding that "he spends his time throwing mudballs at me, when he should be talking about what he stands for."

Although Fitzgerald's strong conservative stance has been depicted by some pundits as too extreme to be electable, he boomerangs the label right back at his

“Good but dangerous news” on health of Medicare Part A

The vital signs may be improved, but the patient is still critical. So stated a 1998 annual report assessing the current health of Medicare Part A.

Released by the Board of Trustees of the Federal Hospital Insurance Trust Fund, the report predicted the fund will remain solvent until 2008, an extension of seven years over previous estimates. Further, the fund’s projected 75-year deficit has been cut in half. Department of Treasury officials credited the Balanced Budget Act of 1997 for the more optimistic outlook.

Theodore Kanellakes, MD, chairman of the ISMS Organized Medical Staff Section, said that, on the face of it, extending the solvency of Medicare Part A is a good thing, but he wonders at whose expense it is being extended. “When I read these reports from the government,” he commented, “I always have concerns. On whose backs is this happening? The public’s? Is it at the expense of quality health care? I look around hospitals and see the nurse-to-patient ratio being reduced to cut costs. Yes, it may help Medicare remain solvent, but what does it mean for the type and quality of medicine patients can expect?”

Although the news delivered by the report seemed upbeat, few believe it signals the end of Medicare’s long-term fiscal woes.

“This is good but dangerous news,” said Rick Wade, senior vice president for communication with the American Hospital Association. “It’s dangerous because some people might look at these numbers, become euphoric and think the pressure is off.

“If we were to have a recession, the situation would flip back. We encourage everyone to keep their eye on the target, which is saving Medicare for the long haul. And seven years is not the long haul.”

Income for the trust fund comes predominantly from payroll taxes. According to Treasury statistics, for every four workers paying the Social Security tax for Medicare last year, there was one Medicare beneficiary. The worker-to-beneficiary ratio is expected to decline in the future, while program expenditures are expected to rise as Baby Boomers retire and encounter health problems.

“There is a tidal wave of Americans who will qualify for Medicare in a few short years,” Wade said. “Who knows what their health needs will be, what the technology will be and how much it will cost?” ■

Medicare+Choice

(Continued from page 1)

health care now, they don’t have to do anything.”

Medicare+Choice plans are open to patients entitled to Medicare Part A and enrolled in Part B, who reside in a plan’s service area, who agree to abide by a plan’s rules after they are disclosed during enrollment and who do not have end-stage renal disease. (Enrollment in MSAs is limited to 390,000.)

Enrollment in Medicare+Choice plans could begin as early as November 1998. Until 2001, enrollees can enroll or disenroll in a managed care plan at any time and choose another insurance option. After 2001, enrollees can only switch plans during certain time frames.

Currently 17 percent of Medicare enrollees are in managed care plans, and HCFA estimates about 30 percent will be enrolled in a Medicare+Choice plan by 2005. A public-information campaign now under development will spread the word about Medicare+Choice. ■

Chicago and U.S. Infant Mortality Rates 1980–1997

Year	Chicago	United States	Ratio
1980	20.7	12.6	1.6
1981	18.9	11.9	1.6
1982	18.6	11.5	1.6
1983	17.6	11.2	1.6
1984	16.4	10.8	1.5
1985	16.5	10.6	1.6
1986	16.5	10.4	1.6
1987	16.6	10.1	1.6
1988	15.2	10.0	1.5
1989	17.0	9.8	1.7
1990	15.6	9.2	1.7
1991	15.1	8.9	1.7
1992	13.3	8.5	1.6
1993	13.7	8.4	1.6
1994	12.5	8.0	1.6
1995	12.6	7.6	1.7
1996	10.8	7.2*	1.5
1997	10.7*	NA	—

Rates per 1,000 live births.

*Provisional

SOURCE: Chicago Department of Public Health

Infant mortality rate sets new low in Chicago

Public health officials expressed optimism as new evidence indicated the city’s infant mortality rate fell slightly from the previous year to an all-time low.

Recently released provisional data from the Chicago Department of Public Health shows that of every thousand live births in 1997, 10.7 babies died before their first birthday – down from 10.8 in 1996 and significantly below the 1995 figure of 12.6. The total number of infant deaths in Chicago also dropped to a record low, 545, down from 570 in 1996.

“Today’s news about infant mortality is certainly something to celebrate,” said

CDPH Commissioner Sheila Lyne. “All of us in public health, from top-level policymakers to our nurses and doctors on the front lines, are encouraged by the new data.”

Driving the good news, Lyne said, was the continuing drop in the number of deaths among non-Hispanic black infants. In 1997, the infant mortality rate in this group registered 16.1 deaths per thousand live births, off from the previous year’s rate of 17.2. The total number of non-Hispanic black infant deaths last year was 342, down from 382 in 1996, and off precipitously from 1990, when 670 infant deaths recorded in Chicago were among non-Hispanic blacks.

Also noteworthy was the fact that in 1997 the infant mortality rate for Hispanics remained steady at 6.5 deaths per thousand live births – the best in the city among racial and ethnic groups. In addition, the number of mothers who reported they smoked during pregnancy dropped to an all-time low of 9.5 percent, down from 15.6 percent in 1989, the first year such statistics were kept in Chicago.

Not all the news was positive, however. The infant mortality rate among non-Hispanic whites increased from 5.5 to 7.7 per thousand live births.

CDPH epidemiologist Glenn Good credited the overall drop and stabilization of infant mortality figures to improved pre- and postnatal care. He noted that supplementing the city’s network of public health clinics – typically located in neighborhoods of greatest need – are a corps of 70 nurses who make home visits to high-risk infants and their parents. Mobile immunization teams offering vaccination services to infants and toddlers, and neighborhood-based health education outreach programs were also cited as reasons for the downward trend of the numbers. ■

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Feds set PSO

(Continued from page 1)

er to secure a position in the market."

PSOs are one option available to Medicare patients through Medicare+Choice, a program consolidating all managed care options for Medicare enrollees. To receive a risk-bearing contract in fiscal 1999 from Medicare+Choice, Murphy said PSOs must have submitted their application to U.S. Health Care Financing Administration by Aug. 1. The agency has stated, however, that it may not be able to review every application in

time to award all qualifying PSOs a 1999 contract.

HCFA's definition of a PSO, according to an ISMS analysis, is a public or private entity formed and operated by a health care provider or a group of affiliated providers. The providers must offer a substantial proportion of health care items and services, share substantial financial risk and hold at least a majority financial interest in the PSO.

PSOs must also apply for a federal waiver that permits them to postpone meeting state solvency requirements for three years, according to the ISMS analysis. In the interim, the waiver allows

PSOs to meet lower federal solvency requirements and all other state health maintenance organization requirements. Waivers can be applied for until November 2002 and are nonrenewable. To get the waiver, PSOs who want to operate in Illinois must first apply and be rejected for licensure as a health maintenance organization from the Illinois Department of Insurance.

Current state solvency standards require providers to raise large sums of money, a prerequisite that may discourage physicians from forming physician-run organizations. But the federal waiver recognizes that some

providers, like physicians, could still furnish health care services to enrollees even if the PSO became insolvent.

The federal solvency requirements mandate a minimum net worth of \$1.5 million – at least \$750,000 of that in cash or cash equivalents – at the time of application. A \$1 million net worth is permitted if the providers can prove that the PSO will possess an administrative infrastructure capable of reducing, controlling or eliminating start-up costs. After the effective date of a Medicare+Choice contract, the PSO must maintain a net worth based on its volume of operations. Its cash requirement is 40 percent of the minimum net worth or \$750,000, whichever is greater.

The waiver allows PSOs to count tangible assets, like equipment and property, toward their net worth. They can also count intangible assets, like intellectual property. Each asset category, however, is limited to a certain percentage of the PSO's initial net worth.

Once the three-year waiver expires, PSOs must shut down or receive state licensure by meeting higher solvency requirements. The organization, for example, would no longer be able to consider intangible assets when calculating its net worth. Murphy said, "You need to use that 36-month time period to get yourself up and running, to get your contract secured and to prepare for what is presently, in Illinois, HMO licensure."

Creating a PSO requires planning, said John Schneider, MD, immediate past chairman of ISMS' Third Party Payment Processes Committee. Financing, contracting, marketing, enrollment, billing, claims processing, information systems and competition are some of the key issues that need to be considered. "Unless you're part of a group that's thought about creating a more formal entity like an HMO, you're probably not going to be likely to set up a PSO."

Another factor to consider is the existing market. "In the greater Chicagoland area, there is already Medicare managed care activity. Do [providers] realistically feel it's in their best long-term interest to create a PSO?" Murphy asked. "In Downstate Illinois or outside the metro Chicago area, that analysis may be very different. There may be less of a foothold in those markets, and rural rates under Medicare+Choice may be, relatively speaking, more attractive."

As a PSO, physicians and others will be able to compete with HMOs for contracts, Dr. Schneider noted. That may create a problem if the group currently has a contract with a future competitor. "The HMOs may say 'Sorry, we're not going to contract with you anymore,'" Dr. Schneider said. "It's a nasty world out there."

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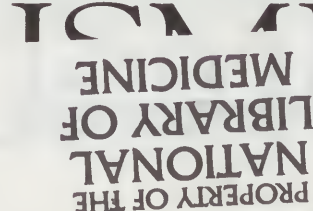


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U.S. House calls
to physicians
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Illinois Medicine

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Physicians
recruited for
war on
domestic violence

PAGE 3

Governor okays flurry of health care bills

Nurses' licensing legislation now law

RATIFIED: New law adheres to ISMS principles; noisy debate brought to quiet close. BY JANE ZENTMYER

[SPRINGFIELD] This session's fight to develop a bill that appropriately licenses advanced practice nurses drew quietly to a close when Gov. Jim Edgar signed an agreed-upon licensure bill Aug. 13.

"The law protects quality health care and expands access

to it by requiring APNs to work in collaborative relationships with fully trained physicians," ISMS President Richard Geline, MD, said.

"Thanks to ISMS' lobbying efforts, this law does not allow advanced practice nurses to practice independently."

Despite the governor's action, Dr. Geline said ISMS' work isn't finished yet. The Illinois Department of Professional Regulation, which will administer the law, must now develop rules that will furnish the practical, everyday details needed to implement it. "ISMS will track

the state's rule-making process to ensure that final rules adhere to the approved law and reflect principles established by the House of Delegates," Dr. Geline said.

ISMS will also keep tabs on the licensure of nurse anesthetists. (Continued on page 14)

Expansion of KidCare set to begin October 1

CHILDREN BENEFIT:
Some copayments and
premiums required.

BY JANE ZENTMYER

[CHICAGO] Now that Gov. Jim Edgar has given his approval to the KidCare expansion, state officials are working out the details that will get the program running by the Oct. 1 start-up date.

On that day, more than 200,000 additional poor children will become eligible for state-sponsored health services.

"The start of such a large undertaking is bound to experience some problems during implementation," said ISMS President Richard Geline, MD.

(Continued on page 12)



As a youthful contingency looks on, Gov. Jim Edgar signs the state's KidCare expansion into law at Children's Memorial Hospital in Chicago. It was one in a string of health care bills the governor recently signed.

Andrew Corrigan Halpern

New Ob/Gyn law orders plans to obey old, ignored law

BY LINDA MAE CARLSTONE

In a victory for patient rights, Gov. Edgar last month signed an ISMS-backed bill that forces managed care plans to inform female enrollees of a law granting them direct access — without referrals or prior approval — to any physician in the woman's insurance plan specializing in obstetrics, gynecology, or family practice.

"ISMS fought to amend the law. We knew patients were not taking advantage of their right to select a women's principal health care provider because they did not know it existed," said ISMS President Richard Geline, MD. "The new law makes it clear that managed care plans must

communicate this information to their enrollees."

The direct access right was initially guaranteed by a 1996 ISMS-prompted Illinois law, but even after it took effect some managed care plans made it difficult to choose an Ob/Gyn as a principal care physician, or even know available physicians' names, according to Rep. Rosemary Mulligan (R-Des Plaines), the bill's chief House sponsor.

"We repeatedly found that women did not know they were allowed to have an Ob/Gyn as a principal health care physician," Mulligan said. She added that several constituents who learned of the law by reading articles in her legislative newsletter called her office to report that their

plans were denying them direct access.

(Continued on page 10)

ISMS helps secure physician Medicaid hike

Illinois increased Medicaid rates for physicians and other providers \$53.6 million, retroactive to July 1, Gov. Jim Edgar announced as this issue went to press. ISMS worked closely with the administration to achieve this action.

The hikes will impact E&M codes and antepartum care. For example, E&M code 99213 jumped to \$30 from \$18.55. ISMS will soon mail more information to members, and further details will follow in the next Illinois Medicine.

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Electronic
death certificates

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MEDICINE

Recommendations from Medical Society endorsed by Gov. Edgar

Gov. Jim Edgar turned to ISMS for recommendations when he recently filled four spots on key state boards. As a direct result of those recommendations, the governor appointed three Society members to new posts, while asking another to stay on a board on which she already served.

Appointed to the Medical Licensing Board were Richard Schmidt, MD, of

Ottawa, a family practice physician with Ottawa Medical Center, and Robert Vanecko, MD, of Chicago, of the division of cardiothoracic surgery at Northwestern University Medical School. The seven-member licensing board advises the Illinois Department of Professional Regulation on the qualifications of applicants for licensure as physicians in Illinois.

Georgia Lubben, MD, of Chicago, a

family physician at the Friedell Clinic, was appointed to the Medical Disciplinary Board. The board's nine members consider allegations of misconduct by medical professionals.

Reappointed to the State Board of Health was Karen Scott, MD, of Palatine, director of the Cook County Department of Public Health. Comprised of 15 members, including five physicians, the board advises the Illinois Department of Public Health on needs assessments, health objectives, policy development and assurance of access to necessary services. ■

Tax check-off fund supports cancer research in Illinois

Thanks to Illinois taxpayers, nearly \$400,000 in the form of eight grants recently went to scientists to be used for breast and cervical cancer research. A key source of the money was provided by the Illinois Breast and Cervical Cancer Research Fund, a check-off fund taxpayers contributed to through their state income tax returns.

Since 1994, 36 breast and cervical cancer research projects have received more than \$1.6 million, with just under one-third of that total coming via the tax check-off fund. Voluntary

income tax funds must raise a minimum of \$100,000 to remain on the state's 1040 tax form.

Invasive breast cancer is diagnosed in approximately 9,200 Illinois women each year, claiming the lives of 2,200 women in the state annually. More than 700 cases of invasive cervical cancer are diagnosed each year in Illinois, and over 200 women die annually from the disease.

"Research into the causes, prevention and treatment of breast and cervical cancer is at a critical turning point," said John Lumpkin, MD, director of the Illinois Department of Public Health, which distributed the grants. "With the help of citizen contributions, Illinois is doing its part to fund the essential research efforts of our state's scientists," he said.

IDPH has announced that after

Sept. 15, 1998, applications will be available for next year's grants from the fund. The grants will support research into the prevention, etiology, pathogenesis, early treatment and behavioral science of breast and cervical cancer.

Anyone interested in receiving an application can call (217) 524-6088. ■

Newly signed law changes state's CME requirement

Listening to ISMS suggestions, Gov. Jim Edgar approved a law in August that outlines the state's new continuing medical education requirement.

Previously, the Medical Practice Act required physicians to earn 50 CME hours per year, or a total of 150 hours, for a three-year medical license. The recent modification lifts the annual requirement, but leaves the 150-hour total in place.

ISMS pushed for the modification so that Illinois law mirrors the requirements physicians must fulfill to earn the American Medical Association's Physician's Recognition Award. The PRA requires 150 CME hours over three years, but doesn't split the 150 hours into annual increments. IDPR will accept the certificate as proof that physicians have earned their CME hours.

Medical licenses expire next year. Given the state's late start in implementing this requirement, the Illinois Department of Professional Regulation has said it will only require physicians to earn 50 CME hours for the July 1999 renewal, and any hours that have been earned since July 1997 will count toward this total.

For the 1999 renewal, that means physicians must earn 20 formal, or Category 1, CME hours and 30 informal, or Category 2, hours. After 1999, physicians must earn 60 formal hours and 90 informal hours for renewal in 2002, and every three years after that. ■

AIDS drug program expansion reflects Society stance

Newly loosened income-eligibility requirements will allow approximately 1,575 individuals with HIV or AIDS to receive monthly help from the state's AIDS Drug Assistance Program – increasing the current patient pool by about 10 percent.

The move follows long-standing ISMS Board of Trustees support of such action.

Since February 1997, the board has been on record advocating support for efforts to establish appropriate funding for ADAP.

Effective Aug. 1, the qualifying financial criteria expanded to include Illinois residents with incomes up to 400 percent of the federal poverty level,

an increase from the current 200 percent requirement. Four times the federal poverty level for an individual is \$32,200.

"As more and more effective drug therapies are developed for people with HIV/AIDS, Illinois must continue to tailor its resources to ensure these critical drugs reach the people who need them," said John Lumpkin, MD, director of the Illinois Department of Public Health, which oversees the program. "ADAP also plays an important role in reducing participants' reliance on Medicaid and other public programs."

ADAP currently has a \$16 million budget that makes 64 drugs, including antiretroviral agents known as protease inhibitors, available to individuals with HIV or AIDS. The program was developed to serve those who are uninsured or underinsured, or lack coverage for medications. There is no copayment for ADAP participants.

Protease inhibitors are being credited with a dramatic drop in AIDS deaths, in Illinois and nationwide. The first protease inhibitor, Saquinavir, was approved by the U.S. Food and Drug Administration in December 1995, with others approved soon after. A decrease in AIDS deaths follow a similar time line. The decline is being attributed in large part to the availability of protease inhibitors.

To receive ADAP benefits, an individual must have AIDS or HIV, must meet the income requirements, must not be eligible for 80 percent or greater insurance coverage for drugs through another third-party payer and must not be eligible for payment of prescription drugs from any other governmental agency.

Physicians should have qualified patients call IDPH at (217) 782-4977. ■



INTRODUCING

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Contact the HELpline at (312) 580-2499.

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Physician aid sought to combat domestic violence

SEMINAR: Attorney general's fight against abuse relies on team approach. BY JEFF BLACK

A project to draw Illinois physicians into a team attack on domestic violence will soon be sponsored by Illinois Attorney General Jim Ryan.

Even as domestic violence reaches an all-time high, it remains one of the state's most underreported crimes, Ryan said. Many victims – the vast majority women battered by male spouses or other intimate partners – refuse to reveal what has happened. Even emergency room and other hospital personnel seeing victims up close are often left in the dark.

The Emergency Department Domestic Violence Seminar – endorsed by ISMS – aims to improve physicians' roles in encouraging victims to report abuse and take advantage of resources to help them through the ordeal. "Illinois physicians play an important part in combating domestic violence throughout the state. By joining with all professions serving in the emergency department, physicians will successfully institutionalize a comprehensive response to domestic violence," Ryan said. "I have long believed the key to addressing domestic violence is developing a multidisciplinary approach to prevention and intervention."

Seventy Northern Illinois hospitals have been invited to the October event, a refinement of a highly successful pilot program launched in 1996, on which ISMS closely collaborated. Programs for Southern Illinois and Chicago-area hospitals will be held at later dates.

Dean Wolanyk, MD, director of emergency services at Harvard Community Memorial Hospital in Harvard, an attending physician at Rockford Memorial Hospital and a participant in the pilot, knows from experience that getting clear, accurate information from victims can be difficult.

"Often the abuser brings the victim to the ER," Dr. Wolanyk said. "He stands right there as she receives treatment. He hears every word, and the victim is terrified to speak. She fears reprisal."

The seminar will stress a "team approach," according to a key creator, Carol Warshaw, MD, director of Behavioral Science for the Primary Care Internal Medicine Residency at Cook County Hospital and co-director of the Hospital Crisis Intervention Project. An ideal multidisciplinary partnership, she said, brings together an ER physician, nurse, social worker and hospital administrator. "It's a true collaborative effort," she added.

Dr. Warshaw stressed that team members must make battered women feel safe, let them know it is okay to open up, to ask for help and access needed services. Questioning victims about their injuries in a nonthreatening manner is central to making them feel safe, Dr. Warshaw indicated. Particular lines of questioning will be offered to seminar participants.

Physicians' legal obligations will also be discussed. While there are certain situations in which physicians are mandated to contact police – felonies, injuries with weapons, etc. – currently in Illinois it is up to domestic violence victims to press charges.

Dr. Wolanyk assured physicians that getting involved will not open a Pandora's Box requiring a large time investment. Time spent actually is minimal because referrals are made to community agencies

that pick up the ball and run with it.

"Health care workers are often action-oriented and sometimes get frustrated that victims don't act immediately on their advice," Dr. Wolanyk said. "But in many cases, they plant the first seeds in victims' minds, their first realization that 'I don't have to take this. There's something I can do.'"

Physicians in private practice are also being encouraged to heighten their ability

to recognize and respond to domestic violence, Dr. Warshaw said. She suggested they seek training and become familiar with community resources. She especially urged physicians in administrative and institutional positions for their support.

Former ISMS President Sandra Olson, MD, enthusiastically endorsed the attorney general's program. It was under her tenure that ISMS got involved with it. "I encourage [ISMS members] to support

their hospitals in this endeavor," she said. "Ask whether they have an organized plan to deal with domestic violence. If not, let them know about this innovative program, so that all Illinois hospitals, large and small, can provide these victims the support they need."

The Emergency Room Domestic Violence Seminar will be held Oct. 1 and 2 at Rockford's Ramada Limited Suite & Rockford Conference Center. For more information, call (312) 811-3374. Participants can earn up to 14 hours of Category 1 credit toward the American Medical Association's Physician's Recognition Award. ■



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REPORT for Illinois Physicians

Blood Glucose Monitors

As of 8-1-98

Diabetic patients are among the most vulnerable among us, due to the chronicity and progressiveness of their disease. These patients are amenable to both educational and clinical interventions that have been shown to slow the progression and/or lessen the severity of the complications of diabetes. Clinical pathways and practice guidelines (available from BCBS and others) address these issues. Careful control of blood sugar is a cornerstone of all such management programs. Such control is enhanced by patient awareness of blood sugars, and by immediate feedback when problems are feared. Home blood glucose monitors provide for this information.

Previously available only to diabetics on multiple daily insulin doses, home blood glucose monitors have now been shown to be of value in the management of most diabetics, even some who may not yet be insulin dependent. BCBS IL has therefore revised its medical policy with respect to this device.

This is a portable battery-operated meter used to determine the blood glucose level by exposing a reagent strip to a small sample of blood. The monitor determines glucose concentration in the patient's blood by measuring the intensity of color change on treated reagent strips. Blood glucose monitors can be effectively used in the home setting by diabetics.

There is also a blood glucose monitoring system designed specifically for use by patients who are visually impaired. These monitors differ from the standard blood glucose monitor by having voice synthesizers, timers, and receptacles for specific placement of supplies to enable the patient to use the equipment without assistance.

Blood glucose monitors enable certain diabetic patients to better control their blood glucose levels by frequently checking and appropriately contacting their attending physician for advice and treatment.

Blood glucose monitors are now eligible for coverage to achieve diabetic control by self monitoring of blood glucose for:

- insulin dependent (type I or II),
- non-insulin dependent (type II), or
- gestational diabetic patients.

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EDITORIAL

To deunify or not? Speak your mind.

The Illinois State Medical Society is at a crossroads in its long existence.

It can continue in unified membership with the American Medical Association and county medical societies, which means if you join one organization, you join all three. It can deunify from either the AMA or the counties, leaving a partially linked membership. Or, it can turn onto an independent highway with no membership links, leaving Illinois physicians free to join ISMS, the AMA or their county society, without joining the others.

This is history unfolding. Illinois' unified policy has been in place since 1950 when AMA dues began. Illinois and Oklahoma were the only states to enter a unified status that first year. Eleven other states climbed on board by 1962.

The current consideration to disconnect from the AMA is not Illinois' first deunification go-around – in fact, far from it. Society documents reveal the first resolution to make AMA membership "optional rather than compulsory" for ISMS members dates back to 1981. Since then, more than 20 resolutions to deunify have followed in subsequent years.

But this is the first time the proposal has progressed this far. As directed by the ISMS House of Delegates, a special committee to study deunification was formed.

The committee is in the process of listening to opinions from physicians in all parts of the state. Next, this group will prepare a report and recommendation on its findings to present to the House of Delegates.

In a highly unusual move, the board called a special HOD meeting for Sept. 19 to have the opportunity to contemplate deunification without distraction from other issues. Normally it meets once a year to set policy. This will be its first special meeting in over two decades.

But the decision is not being made in a vacuum. Your delegates – who will ultimately cast the deciding votes – want input from as many members as possible.

The special committee has already heard many individuals and organizations speak out on an array of sentiments, both pro and con: the freedom of choice, the power of flying solo, what the AMA does for them, what the AMA does not do for them, the high cost of dues, the benefits of organized medicine. And, of course, the good and bad of the Sunbeam affair.

So members, speak your mind. Anyone who has not yet conveyed their thoughts on this matter to the leadership should do so now. The people with whom the decision rests – your delegates – do not want to choose this vital course without getting direction.

PRESIDENT'S LETTER

Converting policy into action – IMPAC's heavy lifting

Richard A. Geline, MD



*For better
or worse,
elected officials
are partners
in health care
today.*

The statewide election coming up in November is only two months away. At stake are all the constitutional offices, the entire House of Representatives, and two-thirds of the Senate seats.

The composition of the next General Assembly has potential to greatly influence how we practice medicine well into the next century. Physician input and participation is a must if we are to retain our role as leader of the health team and guardian of quality care in a rapidly changing health care environment.

As physicians we can participate in a number of ways:

- Write to members of the General Assembly speaking as constituents and voters.
- Speak with patients and encourage them in turn to contact their representatives and senators.
- Support ISMS and enlist colleagues not already members to join.
- Support the Illinois State Medical Society Political Action Committee.

Members constantly tell us that legislative action is the most valuable benefit of ISMS membership. IMPAC is how physicians convert policy to action. While ISMS, through our House of Delegates, analyzes problems affecting the quality of medical care in our state and devises solutions, IMPAC does the heavy lifting of supporting candidates who are ready and willing to implement those solutions.

For better or worse, elected officials are partners in health care today. The Illinois General Assembly considers 400 or more bills a year that affect what doctors do and how we do it. Some, like the Medical Practice Act, build a foundation for the quality of care. Others, like the managed care patient rights bills we actively support, are needed to protect that foundation from erosion by forces outside the patient-doctor relationship. Then there are those, such as

the various physician-profiling schemes introduced over the years, that would just be wastefully ineffective.

Don't you think your profession and your patients need a say in who is writing and voting on those bills?

While ISMS reflects our minds, IMPAC shows our muscle. And it can't succeed on good wishes and handshakes alone. Money, quite realistically, is the fuel on which the political system runs. Doctors didn't invent that system. We don't even have to like it. But to be effective in protecting the quality of patient care we must be able to work within it.

Our opponents certainly understand that. Faced with the enactment of lawsuit reform in 1995, trial lawyers built a war chest with a special assessment on their members. To show how seriously they took the matter, leadership of the trial lawyers made making the contribution a requirement of membership. 'Pay up or get out,' they said. Almost all the members paid. As you well remember, the reforms were eventually killed in the Illinois Supreme Court.

As a result of this action IMPAC has committed to greater involvement in judicial races. Having laws passed only to be struck down by unfriendly courts serves no purpose. We must work to see that justices are in place who will interpret law and respect the prerogative of the General Assembly to make law.

All of our goals, our hopes and our dreams mean little if they remain as words in reports neatly stacked on a shelf. Converting policy into law and regulation with meaningful impact on everyday practice is the real goal to which we strive.

The time is now. The need is great. If you are not a contributor to IMPAC, please become one. If you have already made a contribution, consider another. After all, it's only our profession at stake.

GUEST EDITORIAL

One man's battle with the managed care monster

By Thomas W. Self, MD

As a doctor who ran afoul of managed care, I find it fascinating to hear the explanations of health maintenance and other managed care organizations for the low opinion the public has of them. For example, the California Association of Health Plans, my state's trade group for HMOs, blamed "a couple of stories being repeated over and over" for their bad image.

The trade group's comment was in response to my victory two months ago in a suit that was one of the first to test new laws in various states, including California, that protect doctors from being punished for ordering appropriate tests and for spending additional time with their patients. Ever since the jury's verdict, my office has been flooded with calls from doctors and patients recounting their own horror stories – and I have yet to hear the same one twice.

I have been a practicing pediatric gastroenterologist in San Diego for more than 25 years. Before the advent of managed care, I had a reputation for being a thorough and careful diagnostician. But as managed care became more powerful and as patients were turned into "cost units," my medical group, now affiliated with various HMOs, began to criticize my thoroughness as amounting to "overtesting," insecurity or indecisiveness. The board expressed concern that I would jeopardize future referrals to the group by managed care organizations, which were concerned with keeping down costs.

When I explained that the tests were appropriate in all cases and that I needed to spend adequate time evaluating each of my patients, my comments were brushed aside. Pressures on me to see more patients increased. In the outpatient clinic, it was not uncommon for a nurse to rap on the door during a patient exam and unceremoniously call out "You're running behind."

Two of my colleagues in the gastroenterology unit resigned from the group, leaving me as the sole obstacle to the "new phase" of medicine. In the ongoing attempt to force me out, too, secretaries

were asked to keep notes of my statements and activities without my knowledge. Finally, on July 14th, 1995, I found a terse termination letter on my desk.

After I was fired, and while I was setting up a new practice across the street, the group's staff told my patients that I had left the state, or that I did not accept their insurance, or that something terrible had happened that they could not talk about. My patients later told me that they felt abandoned and were confused and frightened by the loss of continuity of care when I was terminated. When it became clear that my patients were in distress and that I would not survive in solo practice if this interference and defamation continued, legal action became necessary.

As disturbed as I was by what had happened to me, I was shocked by what came out at the trial. The smoking gun of the case came when a letter written to the president of my medical group by a top official of a managed care organization surfaced during the discovery process. It pointedly warned that the organization did not wish its patients to be referred to me because I ordered too many "costly tests" and because I was a "provider" who "still doesn't understand how managed care works." If the president could not solve this problem, the letter insinuated, patients would be sent elsewhere. Within a month, I was secretly written out of the budget for the coming year, and about three months later, I was dismissed.

It also came out at the trial that while the younger doctor hired to replace me had generated enormous revenue in a short period and was commended by the medical group for doing so, he was involved in several medical incidents, including the death of one child and serious injury to two others. The medical group reached an out-of-court settlement, the doctor's privileges at the hospital were dropped and he is no longer with the group.

After a three-month trial, the jury found that the reason for my termination was to save money for the managed care



"These days there's lots of hassles being a doctor. Maybe you'd be better off becoming a cowboy."

organization and my group. The jurors relied on California Business and Professional Code 2056, whereby a doctor may not be dismissed for advocating appropriate care for patients. They also awarded defamation damages because of the untrue and disparaging remarks the medical group circulated in an effort to discredit me. (The verdict will not be appealed, because the medical group quickly settled before the punitive damages phase of the case.)

From the enormous public and press attention given to the verdict in my case, it is clear that many Americans are unhappy with managed care. Despite all the political noise about reform, HMOs still hold the high cards. In California, for example, a committee in the State Senate recently approved a bill that would allow a health plan to choose its own reviewer to consider the appeals of patients who had been denied coverage for particular tests or procedures. The measure would also not require the HMO to pay for treatment the reviewer recommends and would exclude from review any treatment that costs less than \$2,000.

Patients continue to be denied vital diagnostic tests and procedures because HMOs and other managed care groups bring pressure on doctors to whittle down costs. It is also discouraging that, in my experience, HMO business executives seemed to expect and receive timely treatment for their children rather than have to wait for the tedious and lengthy treatment authorizations that regular HMO plan members must endure. Also, in two instances, I was

told to do whatever was necessary, with no thought given to cost, by the executive whose children were being treated.

Don't misunderstand – I am personally not against the concept of managed care, but rather against the evils it can generate. A well-organized managed care system can prevent the disparity of treatment where one HMO authorizes even acupuncture and biofeedback while another balks at allowing procedures like bone marrow and organ transplants. HMOs must allow independent and objective reviews of cases rather than rely on cursory checks by doctors who are eager to placate their powerful HMO customers.

Surveys show that patients' faith in health maintenance organizations and in doctors has badly eroded. This inherent distrust of doctors and their recommendations can only undermine the traditional physician-patient relationship, which is so vital to successful treatment.

After the verdict in my case, I received a congratulatory letter from a well-known pediatric surgeon in California. The rewards of being a doctor, he wrote, are "largely measured in identifying what is best for a patient and then having the opportunity to do what one believes is correct and best for that patient." If medicine will heed this doctrine under all circumstances, the tendrils of greed inherent in managed care will not be able to find fertile soil in which to take root and grow. ■

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Quotables

Publications speak out on managed care

act would allow anyone who collects health information, including hospitals, HMOs, doctors, pharmacies and insurers, to provide that data to any health care provider or health plan for 'health care operations,' a broad term that includes case management and setting health plan ratings for companies. The bill does not prohibit any subsequent release of the data if the release doesn't violate

"Under a little-noticed provision in the House GOP Patient Protection Act of 1998, health care companies would have broad rights to disclose or sell patient information. This would preempt many state laws restricting such practices. The

state laws. The bill could legally protect a practice that has recently generated controversy. CVS, Giant and thousands of individual pharmacies were sending patient prescription information to a Massachusetts company, which in turn mailed out product pitches on behalf of pharmaceutical manufacturers."

– From PIAA Newsbriefs, July 27, 1998

"Who knows what surprises will be hiding in the 200+ pages of the patient protection bill? We do know that the marquee issues are in: gag rule ban, ER access, direct access to Ob/Gyns, health plan disclosure, point-of-service offering mandate, improved MSAs, new HealthMarts (whatever they are), and the kitchen sink. Something for everybody.... What else is lurking in the dark recesses of

the bill? Do you think for a moment that Congress is going to pass pro-physician legislation without exacting something in return? We won't know for sure until the ribbons and wrapping paper come off this present."

– From Kansas Physician, July 1998

"We have forgotten, or perhaps we have chosen to ignore, the fact that medicine cannot be practiced without doctors. When a managed care firm throws a contract at you, your hospital or your academic institution, don't just sign on the dotted line while meekly mumbling, 'otherwise I'll be left out.' Just say NO! Managed care needs doctors and hospitals, but we don't necessarily need them!"

– From Medical Sentinel of the AAPS, 1998

Coming soon:
Will you
beat the Y2K
clock?

ISMIE Update

Disconnecting telemedicine

Liability

Cutting-edge
technology linked
to emerging risks

BY JANE ZENTMYER

The advent of telemedicine brings with it exciting, new health care possibilities, such as providing rural areas with access to previously unavailable services. But the excitement is tempered by the knowledge that the country's legal system has yet to catch up with the technology's growth.

"There are still more questions than answers with regard to liability issues in the telemedicine arena," said Lori Bartholomew, director of loss prevention and research at the Physician Insurers Association of America, of which ISMS is a member. Despite minimal guidance from existing case law, the PIAA, physicians and others have begun examining the potential liability physicians face, as well as steps they can take to reduce that risk.

According to Illinois law, telemedicine is defined as a written or oral opinion about an Illinois patient's diagnosis or treatment that is conveyed via telephone, electronic or other types of transmission.

Although radiologists have the most experience with telemedicine, the technology's advantages have spurred other specialties into using it.

For example, in July a new pediatric cardiology telemedicine program linked neonatal echocardiogram monitors at Silver Cross Hospital in Joliet via telephone lines with those at Children's Memorial Hospital in Chicago. A teledermatology program also started earlier this year allows dermatologists at Edward Hines Jr. Hospital in

Hines to diagnose skin conditions of patients at the Joliet Primary Care Clinic via a television monitor.

Liability issues associated with telemedicine seem to have gelled into the following distinct areas: standard of care, licensure, confidentiality and informed consent. Despite the lack of legal guidance in these areas, Bartholomew said, "for now, the best ways to minimize liability risks in telemedicine are much the same as in other areas of medical practice — utilize good judgment and skills, communicate thoroughly and document completely."

The accepted standard of care generally measures the degree of care performed by clinicians in the same or similar locales. But, according to the PIAA's "Telemedicine: A Medical Liability White Paper," telemedicine's ability to cross state lines may substantially alter how standard of care is defined.

Some experts have even suggested that telemedicine may make a high-tech consultation part of the standard of care. Leonard Berlin, MD, professor of radiology at Rush Medical College and chairman of radiology at Rush North Shore Medical Center, phrased a possible legal challenge to physicians like this: "Are you telling me that this radiograph could have been televised to an expert in San Francisco in a matter of two minutes, and you could have gotten an immediate reading, and you didn't avail yourself of that expertise?"

The PIAA agrees in its report that "telemedicine blurs the locale rule and shifts the standards to a national level." The report concludes, "An increas-

ing number of professional organizations are developing national standards, and the growth of telemedicine will reinforce the need for national evaluative measures of care."

Another key legal issue still brewing in the telemedicine arena relates to licensure, said John Blum, an attorney and associate dean for Health Law Programs at the Loyola University Institute for Health Law. Depending on the state, physicians may have to obtain a state-issued medical license before they can legally treat patients via telemedicine.

Illinois, for example, requires both in- and out-of-state physicians to possess an Illinois medical license before using telemedicine to treat patients within state boundaries, Dr. Berlin points out. But the state's telemedicine licensure requirements exclude the following: periodic consultations between a licensed Illinois physician and someone outside the state, second opinions provided to physicians and follow-up diagnoses or treatments if the Illinois patient was initially treated in the state where the original physician is licensed.

A movement to create a national telemedicine license hasn't gotten off the ground yet, Blum noted, so each state can dictate requirements physicians must meet before they can treat patients within its boundaries. Until the issue is resolved, physicians should research state licensure laws before using telemedicine to treat patients across state lines, he said.

Electronic communication also raises concerns about the confidentiality of a patient's

Technology 4-1-1: Tips to prevent legal hassles

Here's some additional telemedicine risk management tips taken from "Telemedicine: A Medical Liability White Paper" published by the Physician Insurers Association of America.



- Become proficient with the technology and know the minimum specifications required to use it.

- Make sure all parties have realistic expectations. The technology is not perfect or appropriate for all types of patient-physician interactions.

- Become familiar with referring physicians and their credentials, and develop an understanding with them about documentation, case management and follow-up responsibilities.

- Educate patients about telemedicine's options and limitations, and make every attempt to personalize the patient's telemedicine experience.

- If the technology does not provide a clear assessment, or results are equivocal, see the patient in person or refer the patient for a face-to-face or follow-up consultation.

PIAA stresses that its recommendations are not telemedicine practice guidelines, but only suggestions based on experts' consensus.

medical information. Some answers on these privacy issues may be provided if Congress enacts pending national legislation by August 1999 as required by the Health Insurance Portability and Accountability Act.

In the meantime, however, one of the recommendations from the PIAA white paper is that physicians and other providers develop an agreement for third-party vendors, equipment manufacturers and systems consultants to ensure they maintain the confidentiality of all records and information. The third party should also agree to indemnify the physician for any breach of confidentiality.

Good documentation is central to defending any lawsuit. The PIAA paper also recommends that documentation for telemedicine encounters include several key elements: pertinent clinical data; the identities of patient and attending family members, participating physicians, all health care support staff and all participating tech-

nical personnel; location of the patient and health care provider; and the date of the encounter, including its beginning and ending time.

With new technologies, obtaining the appropriate informed consent and documentation of it becomes even more important. Documentation for informed consent should include the following: citation that telemedicine will be used, the encounter's perceived limitations, potential risks and consequences, the roles of all involved providers, confidentiality assurances and alternate options.

(See related sidebar for other risk management suggestions.)

"There's no question telemedicine is coming," Dr. Berlin concluded. The technology's promised benefits have spurred its growth even though answers to many questions about telemedicine's liabilities remain elusive. "Right now, we have to stay alert to new developments, have an open mind and look forward." ■

MALPRACTICE ROUNDUP

Brain damage case ends in defense victory in \$22 million suit

A San Diego jury returned a "complete defense verdict" in *Rios v. ASMG*, a suit that arose from a 1995 incident in which a woman fell from the hood of a moving car, suffering a closed-head injury. Diagnosed with a cerebral concussion and admitted for observation, the patient was given a physical, and X-rays of her spine were taken. No CT scan of her head was made.

According to the August 10, 1998, issue of *The National Law Journal*, within two days the patient showed signs of neurologic deterioration. A CT scan was ordered on the "combative" patient, who required anesthesia in order for the scan to be taken. Bilateral frontal lobe contusions and evidence of brain herniation were revealed. When the patient deteriorated further, she was put into ICU and placed on a ventilator.

Now a spastic quadriplegic with severe cognitive deficits, her family sued the hospital, a critical-care fellow on call when the patient initially began to deteriorate and several anesthesiologists, seeking over \$22 million for failure to correctly diagnose and treat her brain damage.

Prior to the trial, the hospital and the employer of the critical-care fellow settled for a total of

\$1.06 million. Two anesthesiologists were dismissed during the trial in exchange for a waiver of costs. The verdict in favor of the defense applied to two remaining defendants.

Jury finds physicians not liable in wrongful death suit

A California jury found for the defense in a wrongful death suit brought against physicians by the family of a woman who died of renal cell carcinoma, according to the March issue of *Medical Malpractice Law & Strategy*. The suit alleged that the physicians' failure to diagnose her cancer in a timely manner caused her death.

Complaining of head and neck pain, as well as nausea, the decedent took medication prescribed by her family practitioner. When the medication proved ineffective, the decedent was referred to the defendant internist, whose diagnosis was disc disease in her cervical spine. A year later, when the decedent changed health plans, new tests were ordered by new physicians. Their diagnosis was renal cell carcinoma. She died two months later.

The plaintiffs claimed that the proper diagnostic tests had not been performed, and that the defendants' failure to diagnose the cancer led to her death. The defendants maintained that their

treatment and follow-up were within the standard of care for treating the patient's complaints.

Appellate court: Physician can be sued for refusing cesarean section

Even if he did not commit malpractice by refusing to perform a cesarean section, a physician can be sued for a violation of informed consent by not complying with a woman's request, a Wisconsin appellate court held in *Schreiber vs. Physicians Insurance Co.* of Wisconsin, reversing a lower court's decision.

According to the April issue of *Medical Malpractice Law & Strategy*, the patient's baby was born with spastic quadriplegia. The woman contended that her infant would have been born normal if the physician had complied with her request for a cesarean section.

Although the patient dropped the malpractice claim, the court allowed the case to proceed under the theory of violation of the informed consent statute, which explains that physicians must inform patients of the risk of various treatment options. In this case, the court ruled that the statute implies a duty to allow patients to make their own treatment decisions if their choices are medically acceptable. The court held in this case that the woman's preference was "medically viable" and that he could perform the surgery.



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The doctors are coming - if congressional elections go well

BY LINDA MAE CARLSTONE

ELECTION
1998
Next in a series
profiling key
Illinois
candidates &
races.

If there is any doubt remaining that health care has earned a prominent spot in American politics, one need only look at the Illinois congressional candidates in the Nov. 3 general election and it most certainly will vanish. There are three physicians running for Congress, a sign of these politically charged health care times.

Among them are Belleville orthopedic surgeon William Price, MD, and Chicago urologist Herbert Sohn, MD. Both Republicans and ISMS members, they



Herbert Sohn, MD

Photo courtesy of Dr. Sohn

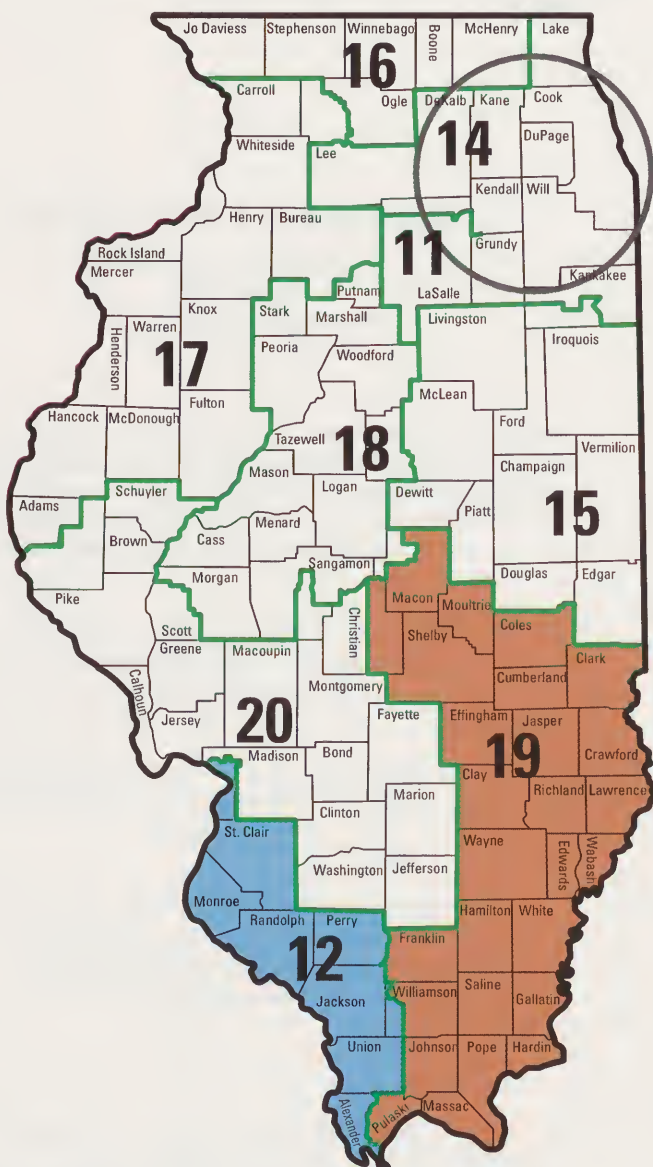
credit the growing need for health care reform as a motivator for their congressional ambitions. "Physicians have to be the voice for patients," Dr. Price said. "I believe I can do more for medicine in Congress than I could by continuing my private practice."

Researching the current congressional debate over a patient bill of rights, Dr. Price recently met in Washington, D.C. with two physicians in Congress: Reps. Greg Ganske (R-Iowa) and Tom Coburn (R-Okla). "They differ on how to solve the problem, but I think the bottom line is we have to make quality health care affordable and accessible," he said.

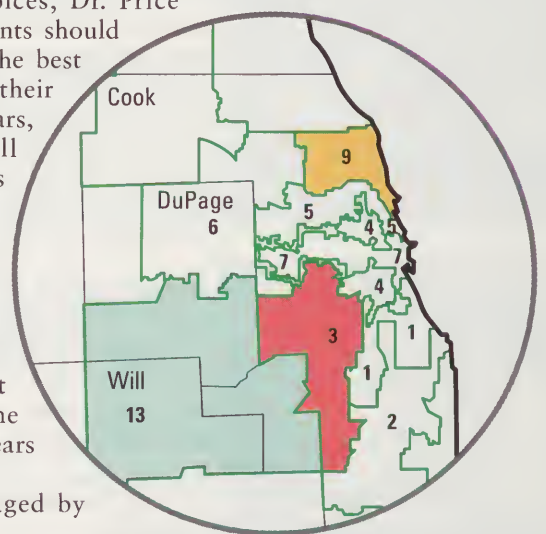
Quality and cost will improve if patients have broader health plan choices, Dr. Price said. He added that patients should be allowed to purchase the best plan for themselves and their families, with pretax dollars, so that individuals will have the same advantages employers do.

The Price name is definitely familiar to voters in the 12th Congressional District. Dr. Price is the son of former U.S. Rep. Melvin Price, a Democrat who represented the same area in Congress for 43 years until his death in 1988.

Dr. Price was encouraged by



Maps courtesy of State
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CANDIDATES FOR U.S. HOUSE OF REPRESENTATIVES

DISTRICT 12 - WILLIAM PRICE, MD

DISTRICT 9 - HERBERT SOHN, MD

DISTRICT 13 - ILL. REP. JUDY BIGGERT

DISTRICT 19 - ILL. REP. DAVID PHELPS

DISTRICT 3 - ROBERT MARSHALL, MD

an American Medical Association poll conducted in May that showed his candidacy electable. He declined to reveal the poll numbers, saying he did not want to tip his hand to his opponent, Democratic incumbent Rep. Jerry Costello. But the poll held enough promise to prompt a \$5,000 campaign contribution from House Speaker Newt Gingrich, as well as a campaign fund-raising appearance by him on Sept. 29 in Carbondale.

Dr. Sohn agrees that health care is the top issue of the campaign. Running for the 9th District seat, Dr. Sohn said the first question he asks voters is: "Are you tired of fighting with insurance companies to get your health care bills paid fairly and quickly? I tell them 'If you are, then vote for me.'"

Citizens, Dr. Sohn said, are sick and tired of the investigations in Washington, D.C., and want to see something done about health care, Medicare and senior citizen issues.

Dr. Sohn is active in organized medicine. He is a former chairman of the Illinois State Medical Society Political Action Committee, former chairman and current member of ISMS' Governmental Affairs Council, and is a member of the Committee on Health Care Access. He is also a past president of the American Association of Clinical Urologists.

Dr. Sohn's opponent, Ill. Rep. Janice Schakowsky (D-Evanston), has not seen eye-to-eye with organized medicine on most legislative issues. She sponsored a bill to place prejudgment interest on malpractice liability and other civil lawsuits, a measure that would have increased malpractice lawsuit judgments. She also sponsored a physician-profiling bill and opposed tort reform.

Other races of interest to physicians will be the 13th Congressional District contest between Ill. Rep. Judy Biggert (R-Westmont) and Susan Hynes of Naperville. Biggert has been friendly to medicine during her General Assembly tenure. She steered bills to passage that guarantee proper hospital recovery time for women and their newborn babies, and for women following mastectomies.

Ill. Rep. David Phelps (D-Harrisburg) is another



Mike Mandis

William Price, MD, District 12 Republican candidate for Congress, reaches out to Michelle Ehlers of Belleville as he campaigns during the recent Marissa Coal Festival and Parade.

state legislator seeking a move to Washington D.C. He is running against Republican Brent Winters in the deep Southern Illinois District 19 currently held by gubernatorial candidate Glenn Poshard.

Another physician running for Congress is Robert Marshall, MD, of Burr Ridge, a GOP candidate challenging Democratic incumbent Rep. William Lipinski for the 3rd District seat. ■

But should they keep practicing in the House?

When Belleville orthopedic surgeon William Price, MD, threw his hat into the ring to run for Congress, he hung his stethoscope up for a leave of absence. The decision to step away from his practice, he explained, was based on his belief that he would not have enough time to devote to both campaigning and doctoring. If elected in November, Dr. Price said, his leave from medical practice will continue.

Despite his decision, Dr. Price said physicians in Congress should not be banned from working as doctors. It is a choice physician members of the House of Representatives were almost forced to make earlier this year before the House Ethics Committee clarified the law's restrictions on medical practice by members.

Initially it ruled that members couldn't charge for any professional services that involved a "fiduciary" relationship, including a doctor-patient relationship. In a compromise

decision that attracted national attention, the committee last February determined that a member's earnings as a physician would be limited to covering business expenses, such as malpractice insurance and licenses.

Physicians are also not permitted to associate their names with a practice.

The committee was interpreting sections of the Ethics Reform Act of 1989 that were created to halt influence peddling situations in which citizens pay money to Congressmen for services in their private occupations as a method to sway votes.

Public awareness of physicians in Congress was recently raised again through the heroic actions of U.S. Sen. Bill Frist (R-Tenn.), who rushed to the aid of casualties in the deadly July shootout in the nation's Capitol.

Currently there are seven physicians in the House and one in the Senate. Some of them continue to work as doctors and some have set that aside

for lawmaking.

Dr. Price said the decision should be left up to the physician. The ability to juggle both duties varies according to the specialty, he said, adding that his specialty, surgery, does not lend itself to part-time work. "Surgeons have to be available to take care of complaints, which can occur at any time. Patients put their trust in you, and you have to be there for them."

But if it can be worked into the schedule, Dr. Price said there are several advantages to continuing practicing, from keeping skills fresh to making Congressmen more cognizant of problems with legislation and regulation on which they are voting. It is also a healthy way for a Congressman to stay in touch with constituents, he said. "The whole concept of a citizen legislature means keeping a hand in your occupation. It keeps you grounded."

If you're not yet registered to vote in November election, you still have time

There still is time to meet the deadline for registering to vote – 30 days prior to the Nov. 3 election. ISMS urges all physicians to exercise their right to vote, and to make sure their voices are heard.

The following are voter-registration guidelines courtesy of the State of Illinois.

- Registered voters must be U.S. citizens, at least 18 years of age by election day, and must have been residents of the precinct in which they register for at least 30 days.

- There are hundreds of registration locations statewide. They include the Offices of the County Clerk and Board of Elections, as well as any local city hall, township or precinct office. It is also possible to register at drivers' license centers and selected state offices. In

addition, many schools, public libraries and military recruiting offices have voter-registration capability.

- Registrants need two forms of identification, and at least one must show their current address.

- Citizens may apply to register to vote by mailing in an application available from voter-registration facilities. The mail-in form must be postmarked prior to the close of the registration period.

- Unless the voter is disabled or in the military, those who register to vote by mail must vote in person at the polling place.

- The State of Illinois mails all voters an ID card confirming registration. Anyone not receiving the card within three weeks of registering should contact his or her election office.

New law orders

(Continued from page 1)

The result was that Illinois residents were left with a good law that was not being enforced. To correct the information loophole, H.B. 3427, signed by Gov. Edgar on Aug. 13, spells out specific steps plans must take to inform their female participants of their full rights under the initial law.

Specifically, it requires: Plans send written notice to all female insureds or enrollees not later than 120 days after the law was enacted; provide such notice to all enrollees at the time of enrollment; thereafter provide it to all existing enrollees at least annually, as a part of a regular publication or informational mailing.

The bill also dictates the exact wording to be used, under the title, "Notice to all female plan members: Your right to select a woman's principal health care provider." The notice tells women how to obtain a list of participating obstetricians, gynecologists and family practice specialists, including a toll-free number to order a copy of that list, which must be sent within 10 days after the call. It also describes the steps to designate a principal health care provider from the list. ■

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What else does the Ob/Gyn law do?

In addition to its patient notification aspects, physicians will likely find of particular interest a nugget in H.B. 3427 that fine-tunes the terms of patients' choice of physician for the law passed in 1996.

The previous law grants women direct access to an obstetrician or gynecologist who is a member of the woman's health plan without the hassles of obtaining referrals or prior approval from their plan.

The new law, signed Aug. 13 by Gov. Jim Edgar, states that an enrollee may be required by the managed care plan to select a woman's principal health care provider who has a referral arrangement with the enrollees' primary care physician, or to select a new primary care physician who has a referral arrangement with the principal care physician chosen by the enrollee.

"There needs to be communication between the two," said Sen. Laura Kent Donahue (R-Quincy), the bill's chief Senate sponsor, explaining the benefits of the clarification. A perfect example of why communication is important, she said, is the recent warnings from the medical community about potential adverse reactions from taking multiple medications.

"If you're taking a medication prescribed by the Ob/Gyn, and your primary care doctor doesn't know this and prescribes another medication, it could lead to a bad reaction," she said.

The new referral restriction also should correct billing confusion physicians and patients experienced under the original law, Donahue said. The previous language would allow enrollees to choose physicians with no referral arrangement, making capitation difficult.

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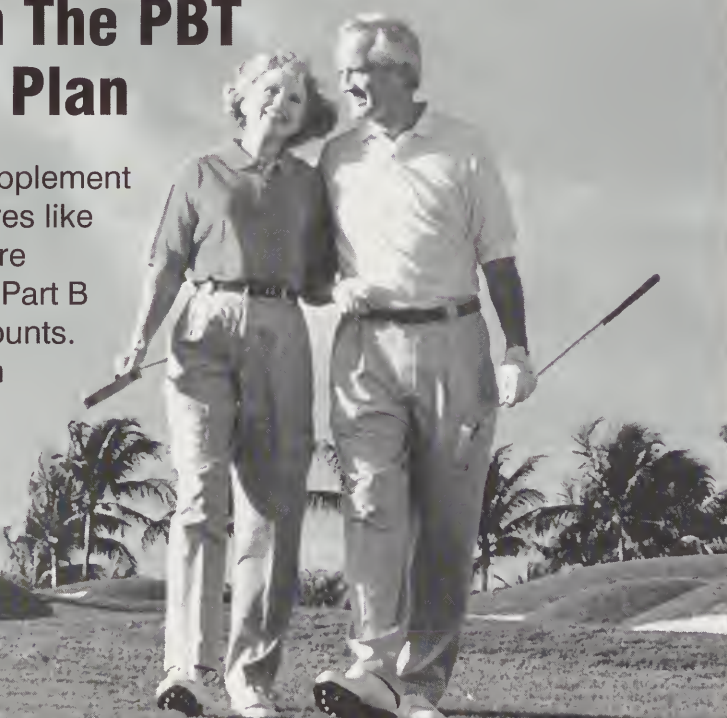
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State to create electronic death certificates

HIGH-TECH: Potential benefits include speed, accuracy; timetable unclear. BY JANE ZENTMYER

[SPRINGFIELD] Computers are quick, accurate and efficient, qualities the Illinois Department of Public Health hopes to build on as it modernizes the creation and processing of the state's death certificates.

The electronic death certificate project – which has ISMS' support – is in early developmental stages and still has some obstacles to overcome, like how to get a physician's mandatory signature on the document. But, according to Steve Perry, deputy state registrar for the Illinois Department of Public Health, it holds the potential to reap benefits similar to those obtained by computer generated birth certificates.

The state currently processes more than 100,000 death records annually, Perry said.

The ISMS Medical Legal Council has reviewed the concept and recommended its support as long as physicians are not required to have access to the computer software, and that appropriate confidentiality and accuracy safeguards exist. The ISMS Board of Trustees adopted this position in April.

attempts to enter a nonexistent or inappropriate date of birth. As a result, Perry said the state has experienced a 95 percent reduction in its follow-up queries on birth records.

The electronic process has also saved preparation time. Previously, records were created using typewriters, but, because a birth record is a legal document, the typist could not use white-out or erasers.

Perry acknowledged that circumstances differ in creating birth and death certificates. For example, IDPH worked with a smaller group – primarily Illinois hospitals – to implement the electronic birth certificate program. The electronic death certificate program, however, at a minimum requires reaching thousands of funeral directors across the state.

Although a physician signature is

optional on a birth certificate, it is mandatory on the death record. Perry said the department is currently researching whether an electronic signature or some other format could be used to guarantee that a physician certified the cause of death.

IDPH has no intention of tinkering with the physician role in the death certificate process, Perry said. "Determining a cause of death is a medical decision, and not anything a funeral director can do."

The project is not far enough along to estimate a start-up date, Perry said, but "The technology is there, and the department is committed to the project." ■

*Electronic access
"will allow state
officials to track trends
and mortality rates
more rapidly."*

– Edmund Donoghue, MD

IDPH plans to make participation voluntary. "We want to develop a system that makes the technology available for physicians," Perry said. "But if a physician says 'I don't want to be bothered by any of this, just do it the old way,' we'll be able to do that too."

Edmund Donoghue, MD, chief medical examiner of Cook County and an ISMS Trustee from Chicago, said one benefit of a computerized process will be more legible death certificates. "At the current time, many death certificates are handwritten," he noted.

Electronic access will also speed up the filing of the death records with the local registrar and IDPH. "The vital statistics will become available more rapidly," Dr. Donoghue said, "which will allow state officials to track trends and mortality rates more rapidly."

The quicker turnaround time will help the deceased's family, according to Dr. Donoghue. Families often need copies of the death certificate to close out financial matters, such as insurance claims and estates.

The push for an electronic death certificate follows a successful electronic birth certificate program, which became operational in 1989.

A key benefit of computerizing the birth certificate process has been the system's ability to catch obvious errors before documents are sent to the state, Perry said. For example, the software displays an error message if someone

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SOME
THINGS
don't.

KidCare

(Continued from page 1)

"Those glitches will have to be worked out as the expansion proceeds."

ISMS supported both this latest KidCare expansion and the first one instituted earlier this year. John Schneider, MD, former chairman of ISMS' Third Party Payment Processes Committee, served on the Children's Health Care Task Force that developed the recent expansion. ISMS, which also participated in the rule-making process by reviewing the proposal and suggesting

changes, will continue to lend advice during the implementation.

An informational notice about KidCare will be mailed to physicians and other providers in mid-September. KidCare applications for children are currently available for downloading off the Illinois Department of Public Aid's Web site at www.state.il.us/dpa/ or by calling (800) 323-GROW. The first participation cards will be issued at the end of September in anticipation of the Oct. 1 start-up date.

The IDPA also plans to mail brochures and applications to all employers, labor unions, community-

based agencies, local health departments and physicians in September, said George Hovanec, IDPA's administrator for the division of medical programs. Physicians and other providers can give an application to a child or their parents during an office visit, and if the application is sent to IDPA within two weeks of the visit, the department will pay for the service as long as the child is KidCare eligible, Hovanec said.

KidCare provides eligible children with health benefits through a state-administered plan patterned after Medicaid or through a parent's employer-sponsored plan via a state subsidy that

offsets participation costs. Under the first option, the benefits available to children will be the same as those provided by the Medical Assistance Program, and physicians will be paid at Medicaid reimbursement rates.

"Nothing is more important than good health," said Edgar in August when he signed the legislation at Children's Memorial Hospital in Chicago. "This program will help children in low-income families get the health care they need to do their best in school and realize their full potential in life."

The governor's action kicked off KidCare's second phase. The first phase was implemented earlier this year when Medicaid's eligibility requirements were expanded to include 40,400 uninsured children and 2,900 pregnant women. Almost \$117 million in federal and state funds will pay for both phases.

Children under the age of 19 become eligible for the KidCare's second phase if their family income falls between 133 and 185 percent of the federal poverty level. That means children from a family of four would qualify for coverage if their household income is between \$21,879 and \$30,433.

No copayments can be charged for immunization or preventive care, but nominal copayments can be charged on most services, based on the income levels of participants. The law caps copayments at \$100 annually per family. But Hovanec acknowledged that enforcement of the cap may pose problems for physicians.

For example, physicians will have to determine if the child's family has exceeded the annual \$100 cap before they charge a copayment. This could be difficult if a family has more than one physician treating its children. Hovanec said the issue is still under discussion. "We're working with [ISMS] on this one," he said.

The copayment for families at 133 to 150 percent of the federal poverty level is \$2 for each medical visit or prescription. No premiums will be charged to this group. Families at 150 to 185 percent of the federal poverty level pay monthly premiums of \$15 for one child, \$25 for two children, and a \$30 maximum for three or more children. These families pay \$5 per medical visit, \$3 for generic and \$5 for name prescriptions, and \$25 for nonemergency use of the emergency room.

Under the KidCare Insurance Rebate Program, the state also will help qualified families pay insurance premiums for coverage under their employers' health care plans. These payments will benefit families with incomes from 133 to 185 percent of the federal poverty level. To qualify, families must have access to private or employer-sponsored insurance and not be eligible for Medicaid.

The employer's health plan doesn't have to meet federal coverage requirements, but it must include comprehensive major medical coverage with physician and hospital inpatient services. Families are responsible for the plan's cost-sharing provisions. Also, the subsidy provided for the children's participation cannot exceed what the state would have paid for the child to participate in KidCare.

KidCare is not considered an entitlement program because the number of enrollees is limited to the funds appropriated.

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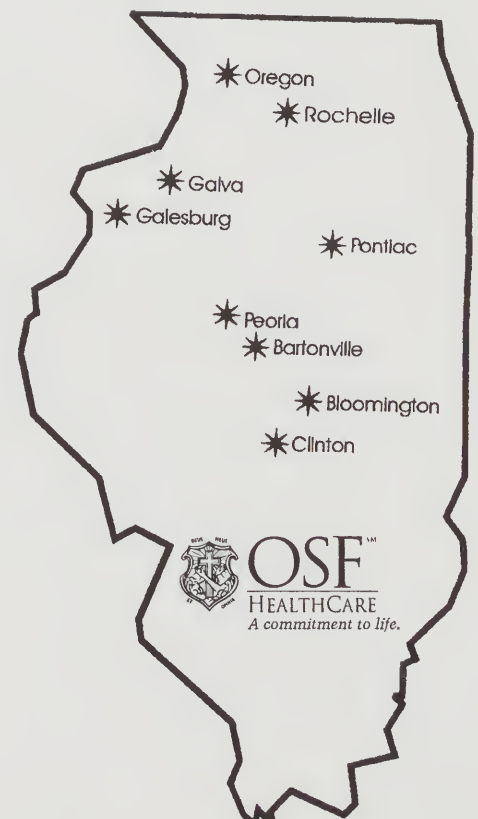
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Nurses' law

(Continued from page 1)

thetists – an issue that remains unsettled because negotiators couldn't resolve their differences by this session's end. A legislative task force will review the outstanding issues related to nurse anesthetists and make recommendations to the General Assembly in April 1999. "When this issue appears again next session, ISMS will work hard to ensure that physicians are involved in anesthesia care issues," Dr. Geline promised.

The new law – previously known as S.B. 1585 – only licenses nurse practi-

tioners, clinical nurse specialists and nurse midwives. It reflects months of negotiations between ISMS and nurses' groups. The ISMS Executive Committee, the ISMS Council on Education and Health Workforce, and medical specialty groups reviewed various proposals, suggesting acceptable changes throughout the session. The ISMS Governmental Affairs Council also reviewed the proposal and recommended its support to the ISMS Board of Trustees.

The governor's recent action on the agreed-upon nurses' bill makes Illinois the last state in the country to legally recognize advanced practice nurses.

The law ensures physician involvement in patient care by requiring APNs to have written collaborative agreements with physicians. Also, the APN may only provide those services generally provided by their collaborating physician. This would allow, for example, nurse midwives to have agreements with physicians who practice obstetrics, but prevent them from having agreements with physicians who don't practice obstetrics.

As part of the collaboration, physicians must provide medical direction, defined as guidelines and standing orders jointly developed and signed by the collaborating physician and APN. Also, the

collaborating physician must first delegate prescriptive authority before an APN can prescribe controlled and non-controlled drugs. Delegated authority can only be given for Schedule III, IV and V drugs; APNs cannot prescribe Schedule II drugs.

ISMS had requested a ratio that would limit physicians to two collaborative agreements with nurse practitioners, clinical nurse specialists and nurse midwives, and four agreements with nurse anesthetists. However, legislators and nurses expressed deep concern about the ratios and asked for an acceptable alternative.

To uphold the spirit of ratios, the bill states the collaborating physician must be in active clinical practice and adds two grounds for discipline to the Medical Practice Act. The first would allow IDPR to discipline physicians who enter into an excessive number of written agreements with APNs, preventing them from adequately collaborating and providing medical direction. The second ground would allow a physician to be disciplined for repeatedly failing to adequately collaborate with or provide medical direction to an APN.

To be licensed as a nurse midwife, clinical nurse specialist or nurse practitioner, the bill requires an APN to be licensed as a registered nurse, earn a master's degree within 12 months after adoption of final rules or by July 1, 2001, whichever is earlier, and receive national certification from the appropriate national certifying body. To maintain their license, APNs will be required to complete 50 hours of continuing education during each two-year licensure cycle.

The bill also gives some nurse practitioners the option to be grandfathered. To do so, however, nurse practitioners must apply for this status by July 1, 2001, must have completed a post-basic education program and must have been in practice for 10 years.

The nurses also agreed with ISMS' proposal to create an Advanced Practice Nursing Board with the power to review and make recommendations to IDPR regarding the licensure and discipline of APNs. The governor will appoint the nine-member board, which will have four APNs, three physicians and two public members, according to the bill. ■



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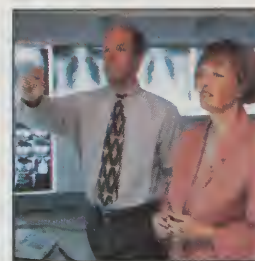
W H E N I T M A T T E R S M O S T

Case in point: Covering physicians

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Illinois Medicine

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Medicine's
friends in key
State House and
Senate races

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Committee to delegates: Deunify from AMA

Final decision to come
at special HOD meeting.

BY JANE ZENTMYER

[CHICAGO] ISMS should deunify from the American Medical Association, a special committee charged with examining the Society's 40-year-old unified policy has recommended.

Arguments favoring deunification far outnumbered those

supporting the status quo, the committee concluded in a 15-page report presented to the ISMS House of Delegates, which will have final say in the

matter. "We felt it would be best not to force doctors to join the AMA, but to make them want to join the AMA," said Steven Malkin, MD, the committee's vice chairman.

The committee recommended against severing ties with the county medical societies.

But the final decision rests with the HOD. On Sept. 19 it will gather - in the first special meeting in more than 20 years - to debate and vote on deunification.

It will take at least a two-thirds majority vote by the HOD to approve a bylaws revision necessary to put deunification into effect, Randall Mullin, MD, chairman of the special committee said. "Any-

thing short of that, and the status quo will prevail."

Delegates will choose among three possible paths: Deunify from either the AMA or the county medical societies, leaving membership partially linked; sever membership ties with both groups; or continue with the current unified membership policy, which requires physicians who join one organization to join all three.

Each of these options, not just the committee's recommendation, have been introduced as resolutions for the House to consider. The House can vote on the bylaws changes during the Sept. 19 session as long as delegates do not amend the bylaws portion of the resolution. Such amendments would trigger a 24-hour waiting period and carry the meeting over to a second day.

Before they even enter Chicago
(Continued on page 10)



E. Ratcliffe
Anderson, Jr., MD

Medicaid's hefty jump

PROGRESS: ISMS helps secure 'record-setting' physician rate hikes; move retroactive. BY JANE ZENTMYER

[SPRINGFIELD] Illinois physicians enthusiastically applauded news that the state infused \$53.6 million into Medicaid's coffers.

ISMS played a significant role in achieving this dramatic increase by working closely with Gov. Jim Edgar's administration and the Illinois Department of Public Aid, according to ISMS President Richard Geline, MD. "We believe this increase represents the largest rate hike in Medicaid's history."

It's an increase that Belleville internist Eldon Trame, MD, said will help physicians continue to care for their patients. "We all see a significant number of patients for Illinois public aid," he said. "In many cases, we almost feel like we shouldn't even bother to turn in billing because our reimbursement is less than the expense of filing a claim."

Of the \$53.6 million, \$30 million was specifically dedicated for physician services. The funds will be used to increase the rates for office visits, prena-

tal care, ophthalmologic exams and family planning services - resulting in rate hikes as high as 61 percent.

For example, an established patient's office visit (coded 99211) will increase almost \$5, from \$8.05 to \$13. And, a new patient's office visit (coded 99203) will increase \$18.20, from \$25.80 to \$44. (See chart for additional examples.)

The increase is retroactive to July 1, and IDPA will automatically adjust claims submitted after that date to reflect the rate hike. Some post-July 1 payments, however, may not include the increase if claims were billed at IDPA's previous rates - instead of physicians' actual charges.

The new Medicaid rates will also be reimbursed to physicians serving enrollees in KidCare - a new program that will provide services to an estimated 200,000 children from low income families beginning Oct. 1.

The substantial rate hike will improve the likelihood that

Poll shows 68 % favor deunification

More than two-thirds of Illinois physicians who responded think ISMS should deunify its joint membership status with the American Medical Society, according to a survey taken in June.

The survey data was one of several avenues of input the Special Committee to Study Deunification examined before recommending that ISMS deunify from the AMA.

The 69-question survey, conducted by the

Coldwater Corp., and accurate +/- 2 percent with a 95 percent level of confidence, was mailed June 20 to 21,400 practicing physicians - 11,600 members, 9,800 nonmembers - to be used for strategic planning. While the subject of deunification was not the primary purpose of the survey, about 10 questions related directly or indirectly to deunification with the AMA and/or county medical societies. Three of those questions were:

➡ **Do you think Illinois should remain a unified state?** Yes: 32 percent No: 68 percent

➡ **Which medical society provides the most value to you as a practicing physician?**

71 percent of all respondents attach the most value to ISMS.

77 percent of ISMS members rate their state society the most valuable.

➡ **If deunification were instituted, would you continue membership?**

• In the AMA, with \$425 dues?

49 percent of current members definitely or probably would.

• In ISMS, with \$500 dues?

57 percent of current members definitely or probably would.

• In the county society, with dues ranging from \$100 to \$475?

51 percent of current members definitely or probably would.

physicians and other providers will accept both Medicaid and KidCare patients, Edgar said when he announced the increase Aug. 26. "This will lead to improved access to health care across the state. More children will receive regular checkups along with necessary immunizations and more pregnant women will receive prenatal care early

and often," he said.

The increase will also act as an incentive to retain physicians already participating in the program, said George Hovanec, IDPA's administrator for the division of medical programs. An increased physician pool means Medicaid patients will be more likely to develop a rela-

(Continued on page 10)

MEDICAID RATE CHANGES

DESCRIPTION	CPT CODES	OLD RATE	NEW RATE
New patient E/M	99201	\$20.95	\$29.56
New patient E/M	99202	\$20.95	\$33.88
New patient E/M	99203	\$25.80	\$44.00
New patient E/M	99204	\$43.45	\$70.27
New patient E/M	99205	\$43.45	\$75.00
Est. patient E/M	99211	\$ 8.05	\$13.00
Est. patient E/M	99212	\$18.55	\$25.65
Est. patient E/M	99213	\$18.55	\$30.00
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INSIDE

Emerging infections
conference

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Physicians get green light to buy Reese, Grant hospitals

A group of physicians seeking to buy ailing Michael Reese and Grant hospitals overcame a significant hurdle recently when the Illinois Health Facilities Planning Board unanimously approved the deal.

The price of the two Chicago hospitals – to be purchased from Columbia/HCA Healthcare Corp. – will be about \$60 million. An additional \$15 million has been earmarked for capital improvements.

The physician group – Reese-Grant Acquisitions Group, representing more than 200 physicians – will put up

approximately \$2 million, with Doctors Community Healthcare Corp., a Scottsdale, Ariz.-based physician's management group, contributing \$8 million. More than \$70 million of additional financing will come from National Century Financial Enterprises of Toledo, Ohio, in return for the hospitals' receivables and medical equipment, which will then be leased back.

Participants hope to complete the purchase some time this autumn.

The proposed sale is viewed by

some as a major test of physician ownership of health care facilities, and will be closely watched. Recent media attention has detailed that, while RGAG physicians are intent on providing high-quality patient care and strengthening doctor-patient relationships, critics wonder if physicians are capable of making tough business decisions that are traditionally the domain of administrators.

If the sale goes through, it will be the fourth time in the last decade the hospitals have changed hands. Michael Reese Hospital opened in 1881, and Grant Hospital was founded in 1883. ■



Kevin O. Mooney

Gore dedicates new facility for infectious diseases

Vice President Al Gore (pictured above) was in Chicago recently to dedicate a specialized infectious diseases outpatient clinic being hailed as a national model.

"The Center demonstrates that fighting HIV and AIDS means more than treatments and infusions," Gore said during a ceremony in the lobby atrium of the new CORE Center, 2020 W. Harrison. "It means path-breaking research, outreach and community education, and counseling for those infected and for their loved ones as well."

The 60,000-square-foot facility will provide individuals and families confronting HIV and other infectious diseases access to comprehensive services in a single location. The center was created through a public/private venture between Cook County Hospital and Rush-Presbyterian-St. Luke's Medical Center. It opens to patients in October. ■

Physicians' support sought to increase flu shot use

The Centers for Disease Control and Prevention has launched a national awareness campaign aimed at encouraging physicians to urge their diabetic patients to get influenza vaccines before flu season, which is generally November through March. It also recommends a pneumococcal vaccine.

Currently, although diabetics are about three times more likely than other people to die from complications of the flu and pneumonia, nearly two in three fail to get a flu shot. Each year 10,000 to 30,000 people with diabetes die from those complications, according to the CDC.

Flu vaccines are expected to be available by mid-September. ■

Correction

An incorrect telephone number was printed in the Sept. 4 issue of Illinois Medicine for information on the Emergency Room Violence Seminar, to be held Oct. 1 and 2. The correct number is (312) 814-5005. ■



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Local conference to address global health threats

EMERGING INFECTIONS:

Illinois not immune from new and resurgent strains.

BY JEFF BLACK

It was a long, hot summer for would-be users of Lake Springfield in the state's capital. A rare infectious disease suspected in the waters – leptospirosis – forced much of this favored recreational site to be closed to swimmers, water skiers and jet skiers.

But more than canceling summer activities, the leptospirosis advisory also contributed to the mounting evidence that Illinois is not immune to the occurrences of emerging infectious diseases cropping up across the world, said John Lumpkin, MD, director of the Illinois Department of Public Health, which issued the advisory.

The Lake Springfield incident is one example Dr. Lumpkin cited in explaining the importance of an upcoming conference – Emerging Infections: Global Challenges . . . Local Solutions – to be held in Chicago on Oct. 6 and 7. The summit will improve medical professionals' effectiveness in responding to these unusual infections.

IDPH and the American Association for World Health are cosponsoring the conference, in conjunction with the Centers for Disease Control and Prevention

and the U.S. Department of Health and Human Services.

Recent headlines leave little doubt that "global" health issues have already crossed the local doorstep into Illinois:

- At least 6,500 people contracted the rare enterotoxigenic *E. coli* bacteria in a mass food poisoning blamed on a south suburban Chicago deli.

- Although reported TB cases are at an all-time low in Illinois, it may reemerge as a public health threat thanks to a drug-resistant strain of the disease.

- Fears remain high that a drug-resistant HIV will jeopardize hard-won gains in the battle against AIDS.

At Lake Springfield, nearly 50 suspected cases of the usually rare leptospirosis – including 36 participants in the June 21 Springfield Iron Horse Triathlon – have been identified in users of the lake, which is closed until further notice.

Dr. Lumpkin said the conference will give global health issues local perspective, especially the serious challenges created by new and emerging infections. He added that the event has been designed for physicians, public health professionals, hospital personnel and pharmacists, as well as for the private sector.

One goal of the two-day event, Dr. Lumpkin said, is to "branch out and build partnerships" within the health care community. Shared resources help devise ways to deal with the rising threat

of emerging infections.

"We want the opportunity to discuss these important issues with physicians and other medical professionals in Illinois and surrounding states," Dr. Lumpkin stated, noting that most conferences on emerging infectious diseases tend to be in Washington, DC, or Atlanta, home of the CDC.

Dr. Lumpkin said that many Illinois physicians are already worried about the

emergence of drug-resistant infections. Strategies for dealing with drug-resistant infections will be one topic of the conference, as will terrorism and infectious diseases, sexually transmitted diseases, and private-sector/managed care involvement in emerging health challenges.

Emerging Infections: Global Challenges . . . Local Solutions will be held at the Chicago Holiday Inn City Centre, 300 East Ohio St. The registration deadline is Sept. 30. For more conference information, contact Gina Swehla at (217) 524-6817. ■

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EDITORIAL

Medicaid boost good news for patients and physicians

The accomplishments of organized medicine are often intangible. Working in a quietly effective manner, the Society remains a reliable resource for physicians, participates behind the scenes in shaping critical legislation and represents patients who have no other voice in the political process.

Sometimes, however, the accomplishments of organized medicine are anything but quiet. That certainly was the case this August when the state added \$53.6 million to the Medicaid budget – a triumph that ISMS worked side-by-side with Gov. Jim Edgar's administration to achieve.

The announcement gave Illinois physicians hard-core evidence that their state medical society is aggressively representing the interests of physicians and patients to obtain adequate monies for the often poorly funded Medicaid program.

Although the increases are not across the board, they do apply to point-of-entry services where most physicians will benefit. The increases target all levels of office visits, prenatal care, ophthalmologic exams and family planning services. The new evaluation and management (code 99212) rate for an established patient will be \$25.65, up from \$18.55.

The rate increases, available to physicians who treat patients eligible for Medicaid and KidCare, is retroactive to July 1.

ISMS worked closely with the Illinois Department of Public Aid and the Edgar

administration to achieve these gains. It is believed to be the largest boost in rates that Illinois physicians have ever experienced under the Medicaid program. Most previous increases have been limited to occasional cost-of-living rate hikes. The last one was in 1996.

ISMS policy has consistently sought adequate medicaid funding; it vigorously represented that goal in the latest rate consideration, which ended so successfully. Without the voice of organized medicine, the outcome might have been a continuation of funding levels threatening access to appropriate health care for Illinois' poor, and for children from low-income families.

While these increases are far from a complete solution to the problem of Medicaid under-funding, they represent a significant step forward in the ISMS mission: assure access to quality health care for all patients. By approving such significant increases, the Edgar administration demonstrated that it shares this goal.

Yes, many times the achievements made by the organized efforts of Illinois physicians are quietly effective; many even go unnoticed. This Medicaid increase, however, proves that the reasonable voice of Illinois physicians does have an impact on health care decisions in this state. With your continued support and cooperation, ISMS will continue to participate in these important victories.

PRESIDENT'S LETTER

Innovative "post-war" plans ensuring patient-first care

Richard A. Geline, MD



"Involve patients up front . . . and assure physicians a place at the bargaining table."

Focused as we are on the fight for patient rights legislation, we can't lose sight of what to do after we win. Good legislation will protect our patients from managed care abuses, but it will not reverse the market forces that produced managed care in the first place.

Once legislation is secured, physicians must help devise creative and innovative approaches to counter those forces. Otherwise we'll find ourselves fighting the same battles all over again, whenever the beancounters think they've found a loophole in the law.

So, where do we start? By examining innovative experiences underway elsewhere – though they may not always be perfect for Illinois. One example I've found interesting is the Oregon Health Plan, "an experiment in democracy," in the words of Oregon Medical Association President Tom Hoggard, M.D.

You probably heard about the OHP when it was created in 1992. A two-step approach toward easing Medicaid's financial instability and expanding access to care for those who couldn't afford it, OHP's first component – moving Medicaid patients to managed care – is no longer a novel idea. But its second element is truly revolutionary.

Oregon developed a list of medical services and procedures, then drew a line on the list. Items below the line were no longer covered under Medicaid. Without using the word (they call it "prioritization"), Oregon essentially developed a rationing system allowing the state to extend Medicaid coverage to everyone at or below 100 percent of the poverty line, and to children and pregnant women at 170 percent of poverty.

The OHP drew its share of criticism. But the state's physicians pointed out it was far more humane to "ration by procedure" than to "ration by people," as the traditional system did.

Six years later, how has it worked out? Dr. Hoggard told me it

has been good for patients, who sometimes find OHP more generous than private insurance. For example, OHP patients are covered for eyeglasses, while patients of HMO Oregon (a Blue Cross plan) are not. Some relatively common items are not covered. For example, OHP covers the diagnosis of allergies, sprains and low-back pain, but does not cover treatment.

Overall, however, Dr. Hoggard said complaints are rare. He credits the extensive process of public hearings and patient/physician input for setting the priority list. And, as Dr. Hoggard, a primary care physician, pointed out, "we still take care of these people."

Not everything has worked out perfectly for Oregon's physicians, however. Dr. Hoggard said the insurance companies running the plan under state contract have forged alliances and/or signed contracts with hospitals to the detriment of physicians. For example, a recent budget increase targeted for physicians appears to have been essentially absorbed by hospitals and plans before it could trickle down to caregivers.

Still, Dr. Hoggard said, doctors want the OHP to succeed, and he believes problems can be resolved through education and negotiation, before doctors are forced out of the plan and patient-access issues emerge. The problems of the OHP are problems common under managed care systems across the country – not problems of Oregon's unique prioritization system.

While the OHP is not necessarily right for Illinois or any other state, Dr. Hoggard offered two suggestions from Oregon's experience I think will be valuable in our "post-war" period, especially as physician innovations develop: involve patients up front, rather than imposing something on them, and assure physicians a place at the bargaining table right alongside insurers and hospitals.

If only the beancounters who imposed managed care in the first place had taken that advice.

GUEST EDITORIAL

IMPAC takes the lead in changing times

By Jere E. Freidheim, MD

Back in the volatile 1960s, when Bob Dylan wrote the words "The times they are a-changin'," he did not have medicine and the advent of managed care in mind. The lyrics, however, are all too appropriate to today's medical community. Accountants and executives make life-and-death medical decisions, while physicians are prosecuted as criminals for using their own medical judgment; collective bargaining – once unthinkable for doctors – is now a reality for some groups of physicians.

Times are indeed rapidly changing. Do Illinois physicians want to stand by and just let that change happen? Or do we want to be part of the process? This is an election year, and physicians need to send a loud and clear signal that we are going to be instrumental in any changes, that we are going to stand up for patient rights – and for our own.

The most effective way to send this signal is through IMPAC, the Illinois State Medical Society Political Action Committee.

The November election is a promising one for physicians; several are showing their commitment by running for public office. Two ISMS members are currently running for the U.S. House of Representatives, William Price, MD, and Herbert Sohn, MD. The Illinois General Assembly has several legislators with health care backgrounds, and two have physician spouses.

Physicians already elected to public office are flexing their muscle as well, influencing health care initiatives. U.S. Rep. Greg Ganske (R-Iowa), a physician, recently stood up to his own majority party and championed real health care reform.

It is up to us to support these candidates and legislators, ensuring that patient rights are protected and that the power to make medical decisions is returned to physicians.

You can guarantee that support by building an ever-stronger IMPAC.

A separate, voluntary, nonpartisan and nonprofit committee, IMPAC carefully screens candidates running in state and federal races, and provides financial support to campaigns in the corner of the medical profession. One hundred percent of every contribution goes to candidates recommended by local physicians on the IMPAC Council, which is responsible for final decisions on the distribution and size of contributions.

While essential, it is an extremely expensive process. The reality is that we are being outspent by insurance interests and trial lawyers – who frequently recruit and back candidates who do not share our views. Those voices will be the only ones heard if we do not act now. We must not shortchange candidates who support ISMS views because IMPAC lacks the necessary funding.

Currently, only 38 percent of ISMS physicians are IMPAC members. The decisions that will be made in Springfield and Washington affect 100 percent of physicians, not just the 38 percent who

support IMPAC. Are you doing your part?

IMPAC's campaign presence sends a clear message that Illinois physicians are active participants in the political arena. The times are changing, but, through IMPAC, you can shape the change instead of being its victim.

The choice is yours.

Dr. Freidheim is chairman of the IMPAC Council. For more information about contributing to IMPAC, call (800) 782-4767 or (312) 782-1654.



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State House and Senate key to balance of power

Physicians seek a happy ending for medicine in the Legislature.

BY JANE ZENTMYER

The battle for control of the Illinois House and Senate again moves to center stage with the Nov. 3 election. The story is about individual races but it carries an underlying theme of who ends up with the power in Springfield. Physicians can play a role in the outcome by supporting candidates whose voting record and beliefs make them medicine's ally.

General Assembly control is now split, with Democrats holding a slim House majority and Republicans holding the Senate majority. While the GOP has dominated the Senate in the 1990s, voters have chosen to bounce House control between Democrats and Republicans.

The General Assembly's composition after this election will depend on the outcomes of at least 20 legislative races — elections that are now considered too close to call by political analysts. GOP or Democratic wins in these districts could swing the majority in either chamber to the other party. (See related story and map.)

Heated debate of managed care reform at both the state and federal levels has captured voters' attention. During her legislative tenure, Rep. Gwenn Klingler (R-Springfield) has been a strong supporter of patient rights, and sponsored ISMS' Managed Care Patient Rights Act.

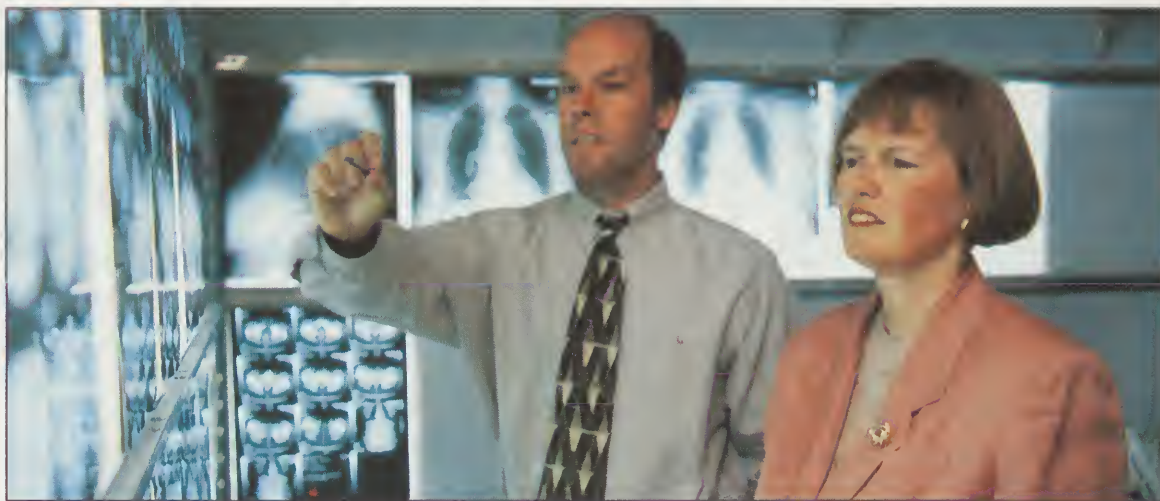
"The wool has been pulled over the eyes of the business community regarding what managed care can and cannot do," said Klingler, whose Democratic opponent is Dave DeFraties, from Springfield. "The assumption is that if you have managed care, you're going to save costs. But, you have to remember that the costs are being saved by denial of services or referrals."

Although maintaining control over costs is important, Klingler said for-profit managed care companies could do a better job of regulating their own spending. "Not enough attention is paid to HMO administrative costs," said Klingler, who cited the multimillion-dollar salaries of HMO executives as an example.

Klingler said that many physicians worry they will not be able to maintain high-quality patient care. "Physicians are concerned that they will not be able to make the best medical decisions for their patients," she added.

Klingler, who is also a member of the Illinois State Medical Society Alliance, was first elected in 1994 to serve the 100th District. She is married to Springfield dermatologist W. Gerald Klingler, MD.

Another House seat up for grabs is in the 103rd District, currently served by two-term Rep. Richard Winkel



As part of her ongoing efforts to stay on top of health care issues, Rep. Gwenn Klingler, an ISMS Alliance member, gets an insider's view of radiology from Andy Sherrick, MD, at Memorial Hospital in Springfield.

Photo courtesy of Rep. Klingler

(R-Champaign). Winkel's record during his House tenure indicates strong support of physician issues.

In addition to voting "aye" for the 1995 tort reform law, Winkel has supported bills that would have provided patients with direct access to dermatologists, insurance coverage for clinical trials, confidentiality for the results of genetic tests and inpatient mastectomy care. He also voted against a bill that would have created a physician-profiling program in Illinois.

"Many physicians have expressed their concerns to me. I take those very seriously and want to work with them," he said. Winkel's challenger, Kathleen Ennen, a Democrat from Champaign, is the former president of the Illinois Nurses Association.

In the battle for control over the Senate, the 19th District is considered crucial. This race pits Sen. William Mahar (R-Orland Park) against newcomer Pam Woodward, a Democrat from Frankfort. Mahar has served in the Senate since 1985 and has been a strong supporter of tort reform and managed care reform.

"I sit on the Public Health Committee and have had the opportunity to work with physicians on issues important to them," Mahar said. "More often than not, my record will indicate that I've been supportive of physicians."

Mahar, a U.S. Army veteran, has a bachelor's degree in psychology from Southern Illinois University and a master's degree in education from Purdue University. He has served on a variety of legislative committees, including the governor's Commission to Review and Revise the Mental Health Code.

Physicians should take stock of the candidates friendly to medicine and support them on Nov. 3. Their ballot may help determine which way the Legislature tips in 1999.



Rep. Richard Winkel



Sen. William Mahar

ate races wer

IMPAC rallies troops, educates physician voters

While many General Assembly candidates are expected to breeze to victory, some candidates will likely experience stormy political weather leading up to election day. Physicians are urged to work hard to elect candidates friendly to medicine, said Jere Freidheim, MD, chairman of the Illinois State Medical Society Political Action Committee.

Reaching out for grass-roots political action, IMPAC has launched an education drive to help physicians identify which candidates will particularly benefit from their help.

"With assistance from IMPAC, physicians and their families can become involved at the local level to help candidates who will support and protect quality health care in Illinois." Physicians can impact the election through financial contribution to IMPAC or striking up conversations with patients, family and friends about the election, he said.

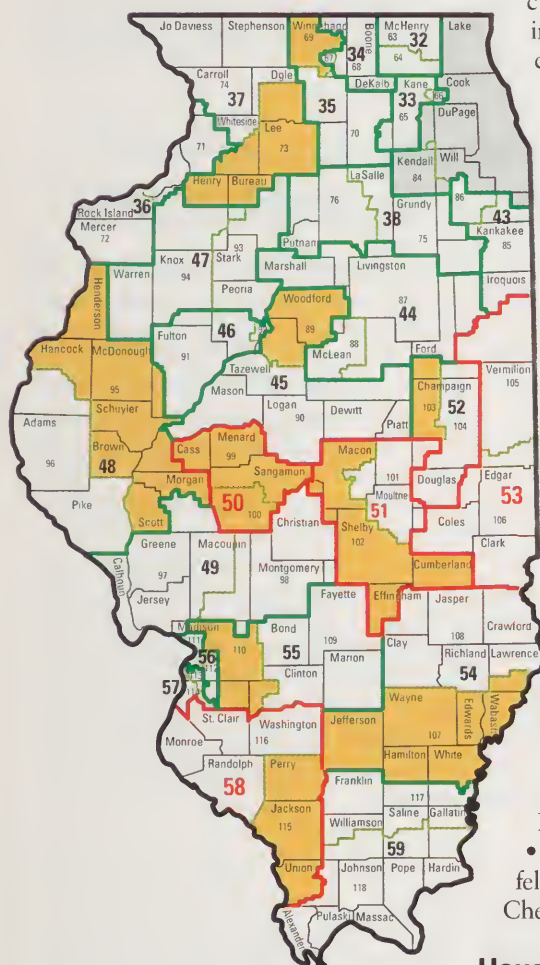
The following races are expected to be closely fought contests in which physicians can make a difference in the outcome:

Senate races:

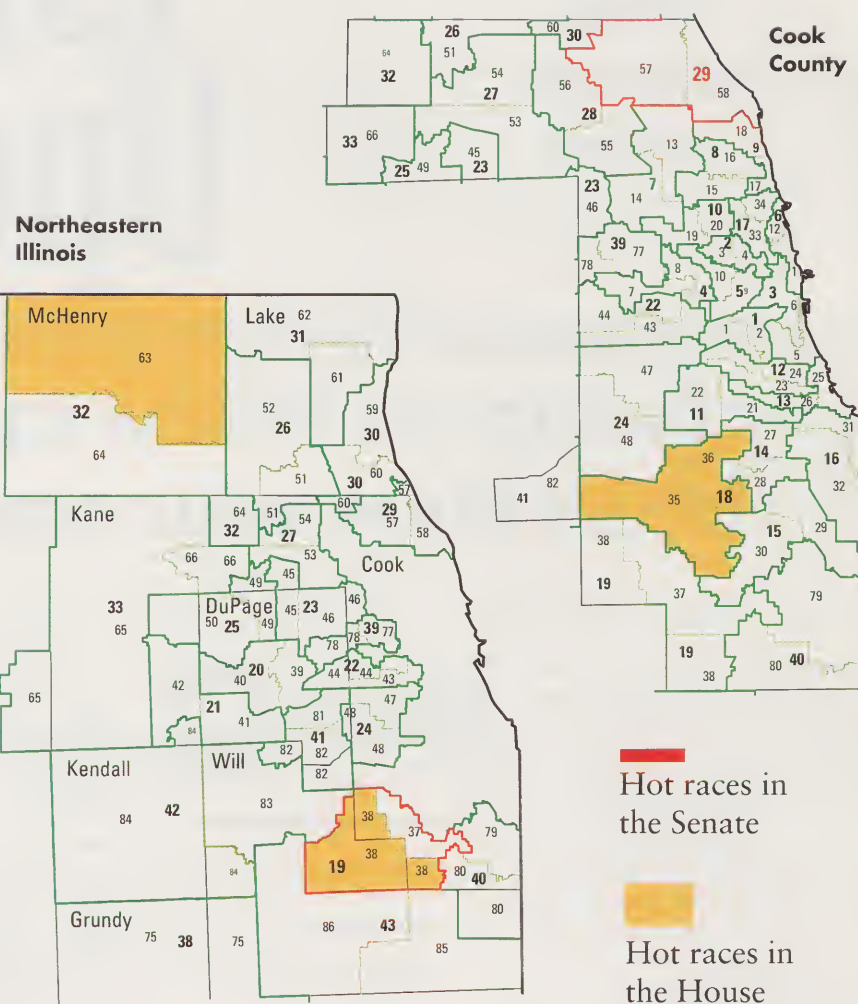
- 19th District; Sen. William Mahar (R-Orland Park) vs. Pam Woodward, a Frankfort Democrat
- 29th District; Sen. Kathy Parker (R-Northfield) vs. Nancy Alessi, a Glencoe Democrat
- 50th District; Sen. Larry Bomke (R-Springfield) vs. Gwen Montgomery, a Springfield Democrat
- 51st District; N. Duane Noland, a Decatur Republican vs. Kevin Kehoe, a Decatur Democrat
- 53rd District; Sen. Judith Myers (R-Danville) vs. Don Roesch, a Danville Democrat
- 58th District; Sen. Dave Luechtefeld (R-Okawville) vs. Barb Brown, a Chester Democrat

House races:

- 35th District; Rep. M. Maggie Crotty (D-Oak Forest) vs. Patrick Burns, an Oak Forest Republican
- 36th District; Rep. James Brosnahan (D-Oak Lawn) vs. John McCauley, an Oak Lawn Republican
- 38th District; Rep. Renee Kosel (R-New Lenox) vs. Scott Pyles, a New Lenox Democrat



Maps courtesy of State Board of Elections



- 63rd District; Rep. Mike Brown (R-Crystal Lake) vs. Jack Franks, a Woodstock Democrat
- 69th District; Rep. Dave Winters (R-Rockford) vs. Verna Hurley, a Roscoe Democrat
- 73rd District; Rep. Gerald Mitchell (R-Rock Falls) vs. Mike Prenevost, a Geneseo Democrat
- 89th District; Keith Sommer, a Mackinaw Republican vs. Mike Goodman, a Metamora Democrat
- 95th District; Rep. Richard Myers (R-Macomb) vs. Mike Beaty, a Macomb Democrat
- 99th District; Rep. Raymond Poe (R-Springfield) vs. Vickie Moseley, a Springfield Democrat
- 100th District; Rep. Gwenn Klingler (R-Springfield) vs. Dave DeFraties, a Springfield Democrat
- 102nd District; Bill Mitchell, a Decatur Republican vs. Lee Holsapple, a Macon Democrat
- 103rd District; Rep. Richard Winkel (R-Champaign) vs. Kathleen Ennen, a Champaign Democrat
- 107th District; Rep. John Jones (R-Mount Vernon) vs. Greg Backes, a Mount Vernon Democrat
- 110th District; Rep. Ron Stephens (R-Troy) vs. Bob Daiber, a Marine Democrat
- 115th District; Rep. Mike Bost (R-Carbondale) vs. Don Strom, a Carbondale Democrat

As part of IMPAC's political education efforts, physicians in these districts will receive IMPAC mailings advising them about candidates' voting records or positions on issues such as tort reform, managed care reform and public health. "Physician support in these elections can really make a difference," Dr. Freidheim said.

He singled out Gwenn Klingler as one candidate who definitely deserves physician backing. Klingler, who is married to Springfield dermatologist W. Gerald Klingler, MD is among only a few members of the medical family who hold a legislative seat, Dr. Freidheim said. "Physicians should step up and be particularly supportive of her campaign."

Call IMPAC at (312) 782-1654 Ext. 1243 for help identifying in which legislative district you reside.

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ISMIE Update

Failure to follow up: Don't blow your cover

BY JAY FERRARI

CASE IN POINT



*"In the absence of
a primary care
physician, the
covering doctor
becomes the
primary care
physician."*

Jim Neville, attorney

Laboratory oversights and poor documentation can be an insidious blend, one that creates an ideal environment to develop lawsuits. When these factors combined during the course of one patient's post operative check-ups, a cancer relapse was missed. And while physicians were busy shrugging their shoulders, lawyers were licking their chops.

The following case demonstrates the profound negative impact poor record-keeping and lack of patient follow-up protocol can have.

THE CASE IN BRIEF: The patient, a 37-year-old male, was diagnosed with colon cancer. A malignancy was surgically removed, and, after a few months of recovery, the patient began postoperative adjuvant treatment.

After six months, the patient was seen by Alice Harkness, MD, his primary physician, to receive a carcinoma embryonic antigen test. The test, which has a normal range of 0-5, often shows elevated results in patients with active colon cancer. The test results came back at .5, safely within the normal range.

While the patient appeared well overall, Dr. Harkness scheduled a follow-up examination six months later. Dr. Harkness, however, was out of town at the time of the next appointment. She asked Stan Vollmer, MD, who sometimes covered her patients when she was unavailable, to step in during her absence.

Dr. Vollmer noted that the patient had a normal physical exam and was without complaints or complications. He also ordered another CEA test, but assumed Dr. Harkness would receive the results, and considered himself out of the loop at the conclusion of the visit. In similar fashion, Dr. Vollmer performed two subsequent follow-up physical examinations at consecutive six-month intervals, substituting

both times for Dr. Harkness. At each examination, Dr. Vollmer ordered a CEA test.

When Dr. Harkness saw the patient again, two years after their first appointment, she was stunned to find a repeat CEA test showed a value of over 500; workup showed evidence of incurable metastatic disease. Her estimation was that the patient had less than a year to live.

In the midst of much finger-pointing by both physicians, and their realization that the lab misplaced the results of several previous tests, the patient's family filed a lawsuit charging that the physicians missed opportunities to extend the patient's life. A jury quickly found in the family's favor.

THE POINTS THIS CASE MAKES: Geoffrey Smoron, MD, is adamant that good communications and consistent procedural double-checking are crucial to physician covering arrangements. Dr. Smoron works at a multiphysician facility in Elgin where arrangements are often made between physicians to cover respective duties during absences. This is only feasible, he insists, when both physicians, as well as the patient, know the particulars of every procedure.

"It is critical that physicians learn the results of any test they order," Dr. Smoron explained. He added that physicians often tell patients that they will call if a result is abnormal, but this does not allow for the occasional scheduling oversight or the misfiled result. "As a matter of policy, I tell my patients to call back so they are informed," Dr. Smoron said.

From the jury's point of view, acting as a covering physician does not reduce a physician's responsibility to follow up with a patient, according to Jim Neville, an attorney with Neville, Richards, DeFrank & Wuller in Belleville.

"In the absence of a primary care physician, the covering doctor becomes the primary care physician," Neville said. "Whoever orders the tests should have a follow-up protocol similar to the referring physician's. This is as much for their assurance as the patient's."

Neville advocates that covering physicians request copies of results, send letters to the primary care physician documenting a fill-in visit, and keep the patient informed. Patients, like physicians, must know who has the responsibility. "Documentation is the key. It might seem like extra work, but it protects the doctors and it ensures things are done well."

Neville suggests a four-step approach to double-checking patient testing and physician coverage.

1. Set up a protocol verifying completion of any ordered test or procedure.
2. Make sure results are returned to the office in two or three days, and, if they are not obtained, follow up with the lab to get those results.
3. Set a standard time period in which to follow up with the patient and inform him or her of the results.
4. Finally, although it will not release physicians from legal responsibility, involve

MALPRACTICE ROUNDUP

Jury splits blame in cancer suit

The son of a woman who died of metastatic breast cancer has been awarded \$250,000 in a wrongful death suit.

According to the July 1998 Medical Malpractice Law & Strategy, after discovering a lump in her breast, the woman was diagnosed by the defendant physicians as having fibrocystic breast disease. Within a month, the lump had doubled in size – but it was not until eight months later that she returned to the defendants. After this visit, she was diagnosed with cancer, which took her life five years later.

In *Gomez v. County of Los Angeles*, the woman's son argued that the defendants negligently failed to schedule follow-up appointments for the decedent in order to monitor her condition. The physicians responded that their treatment was within the standard of care, adding that the decedent was at fault for not scheduling an appointment when she noticed the rapid growth of the lump.

Sixty percent of the liability was apportioned to the defendant physicians by the jury, with the remaining 40 percent apportioned to the decedent.

Mutual membership does not exclude expert witness from malpractice case

The Supreme Court of Oklahoma recently reaffirmed that membership in a medical malpractice insurance company does not render the testimony of a defense expert biased when the defendant is also a member of the same company.

According to the July 13 issue of *The National Law Journal*, the reaffirmation came in the wake of a case *Donna Marie Holm-Waddle* brought against William Hawley, MD. The plaintiff alleged that, during her mother's bypass surgery, the physician had caused the woman's silicone breast implants to leak into her chest, which caused death.

After the jury found for the defense, Holm-Waddle appealed, asserting that the court excluded evidence that both the defendant's expert witness and the defendant belonged to the same mutual medical-malpractice insurance company.

Justice Ralph Hodges made it clear that to demonstrate bias substantial enough to show a danger of prejudice the connection between an expert witness and a defendant's insurer must be more significant than mere membership in a mutual insurance company.

patients by prompting them to contact the physician if they do not get the test results within a week or two of the test.

Having any one of these actions in place would have made all the difference in the drastic legal results of this case. Their lack, however, caused a communication breakdown; Dr. Vollmer presumed Dr. Harkness would see the test results, and Dr. Harkness thought Dr. Vollmer was making sure the

lab applied the results to the patient's charts. Neither confirmed the actions of the other.

The law will always see the physician as the responsible party, Neville concluded, so no follow-up protocol can be too meticulous in tracking test results or confirming findings of a covering physician. ■

Case in Point uses hypothetical case histories to illustrate key risk management issues.

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Deunify from AMA

(Continued from page 1)

go's Palmer House Hilton to deliberate, delegates will have the report produced by the Special Committee for the House of Delegates to Study Deunification. The 13-member special committee was formed to conduct an in-depth investigation of the pros and cons of unification and deunification at all levels of organized medicine, and make a recommendation. Delegates authorized its creation at the ISMS Annual Meeting in April. The speaker and vice speaker appointed grass-roots physicians to

serve on the committee.

"We listened to anybody who wanted to give us their opinion, and we studied testimony from physicians all over the state, as well as solicited input from the AMA," said Dr. Malkin.

Much of the testimony before the committee focused on physicians' concerns about unification with the AMA, according to the committee's report. Little testimony and factual support was given to justify severing ISMS' membership link with county medical societies, and the committee recommended against this action.

Physicians favoring deunification cit-

ed a high level of dissatisfaction with the AMA. The national organization, they told the committee, fails to respond to physicians' economic concerns, fails to aggressively represent physicians and patients' best interests, and reacts slowly to national issues affecting physicians.

Disillusionment with the AMA was also attributed to the way in which it handled two well-publicized issues. Specifically, physicians believed the AMA abdicated leadership during the 1997 revision of the evaluation and management codes. The national organization also damaged medicine's credibility by agreeing to the now-defunct Sun-

beam endorsement deal, they testified.

Still, others believe they should have the freedom to choose which organization to join, and they decried the high cost of dues mandated by membership in three organizations. Physicians in the ten largest county medical societies pay an average of \$1,255 annually – \$420 to the AMA, \$500 to ISMS and from \$200 to \$550 for their county medical society.

In reaching its decision, the special committee also considered a recent ISMS physician poll in which 68 percent of the respondents favored deunification. (See related story.)

Although in the minority, some testimony addressed unification benefits. Chief among them is that a large, united force of physicians will help the AMA convey a strong message to Washington. Deunification may weaken the AMA and erode its ability to successfully negotiate for physicians on national health care issues, some physicians argued.

AMA Executive Vice President E. Ratcliffe (Andy) Anderson, MD, acknowledged to the committee that the AMA has handled some matters poorly in recent years, but asked for one more year to prove to ISMS members that changes will be made at the national organization.

Concerns also were expressed that deunification would be played by the media as a further division in the house of medicine, especially since Illinois is the AMA's "home state." Illinois deunification could lead to "copycat" actions among the remaining three unified states and two unified specialty societies, some physicians feared.

Two members of the special committee dissented from the majority's decision, citing their belief that medicine's long-term interests would be better served by remaining unified.

If delegates vote to deunify, the decision becomes effective immediately, in time for the 1999 membership year. ■

Hefty jump

(Continued from page 1)

tionship with a physician rather than rely on outpatient clinics for treatment, he said. "It's an attempt at making mainstream medicine more easily attainable for our clients."

The last increase occurred in 1996, when the governor signed off on a 3 percent rate hike for all services. A significant increase of 13 percent occurred in 1993, but it only applied to dedicated services covered under the now-defunct Healthy Moms Healthy Kids program.

"This substantial rate increase is a step toward making the state's rates truly competitive – but it hasn't solved the underfunding problem," Dr. Geline said. "ISMS will continue to work with state officials to ensure access to top quality care for Medicaid and KidCare recipients."

In addition to \$30 million for physicians, \$23.6 million will be split among other types of providers: about \$8.5 million for dentists; almost \$8 million for health maintenance organizations; and almost \$7.1 million for nurses, audiologists, chiropractors, optometrists and others.

Physicians with questions about the rate increase can contact the ISMS Division of Health Care Finance at (800) 782-ISMS. ■



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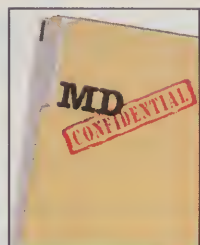
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Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • OCTOBER 2 1998

Ryan's
race for
the top

PAGE 3

ISMS House rejects special committee recommendation

DECISION: ISMS to stay unified with AMA. BY JANE ZENTMYER

[CHICAGO] Rejecting the recommendation of its own special committee, the ISMS House of Delegates voted at a special meeting held Sept. 19 to remain unified with the American Medical Association.

While it received majority support, the 81-80 vote for AMA deunification fell far short of the required two-thirds

**County decision
on page 14**

vote of credentialed delegates needed to implement a change in the Society's bylaws.

The three-and-a-half hour meeting, held at Chicago's Palmer House Hilton Hotel, provoked strong opinions on

both sides of the deunification issue. However, ISMS President Richard Geline, MD, said that "the one area not in dispute was the need for a strong voice for organized medicine. The only question seems to be how to get there."

The Special Committee to Study Deunification made its recommendation to deunify from the AMA after listening to physicians on both sides of the issue, collecting historical data, and examining membership data and results of a statewide survey. The 13-member committee was appointed by the speaker and vice speaker after the House approved its creation in April.

In summarizing its 15-page report, committee members noted that more than 68 percent of Illinois physicians who responded to an ISMS survey think the Society should deunify from the AMA. While the subject of deunification was not the survey's primary purpose, about 10 questions related directly or



Delegates at special ISMS House of Delegates meeting stand to register a vote.

indirectly to deunification.

Steven Malkin, MD, the special committee's vice chairman, also noted that more members canceled their membership in 1998 than in any of the previous years this decade. ISMS membership as a total of the physician market is declining, and the Society is not attracting young physicians into full dues-

paying membership status, according to the report.

Physicians at the grass-roots level clearly indicated through this poll that they want the dues structure to be deunified, point-

(Continued on page 12)



DuPage County delegate Chennai Indiraraj, MD, weighs his decision.

ISMS Deunification Timeline

1950 - AMA dues begin

AMA charges for membership, breaking the previous policy of automatic, dues-free enrollment for every physician joining his or her state medical society. Previously, dues were unnecessary because JAMA advertising revenue alone was enough to finance AMA operation. Illinois and Oklahoma become the first unified states, meaning that members of the state society must also pay dues to the AMA.

1962 - Unified membership peaks

Eleven other states join AMA union. This represents the height of a period, between 1950 and 1970, when unified states dominated the AMA's elected offices.



1971 - New York first to deunify

First out, New York's state membership was steady after 1971, but AMA membership dropped by almost 60 percent - a statistic many cited as prophetic of state regard for unified membership. During the next few years, Arizona, California, Colorado, Delaware, Kansas, Mississippi, Montana, Nebraska, Nevada and Pennsylvania follow suit and renounce their unified status.

1972 - Colorado deunifies

While membership was stable in the Rocky Mountain state, it soared in the wake of deunification - up 122 percent by 1981. In the same time, AMA membership dropped 32 percent.

1981 - Illinois' first formal deunification consideration.

The first ISMS resolution to make AMA membership "optional rather than compulsory" is introduced on April 5. This proves to be the first of what will be an array of similar resolutions to deunify proposed regularly for the next 17 years.



August 12, 1998 - Time to talk

A day devoted to testimony before the ISMS Special Committee on Deunification. Six physicians, including the chairman of the Illinois Delegation to the AMA, members of several county medical societies, and the executive vice president of the American Medical Association detail their positions on the issue.

September 19, 1998 - Verdict is in

The ISMS House of Delegates in a special meeting (shown below) rejects deunification.



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**Alcohol-related
traffic deaths drop**

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screening**

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John McNulty



COLLEEN GALLAGHER, RN, gives a free immunization to an anxious Alex Noé Carriedo as Leo Niederman, MD, looks on during the 14th Annual Back-to-School Health Fair at Benito Juarez High School, Chicago.

Physicians asked to screen for depression

Illinois physicians are being asked to participate in a national screening day to identify patients who may be suffering from depression. On Oct. 8, National Depression Screening Day, participating physicians will request all their patients who have regularly scheduled appointments to answer a 10-question test.

Free screening materials, including the brief test that patients can complete in the waiting area before their appointments, will be provided by the National Mental Health Association. Materials

include test instructions created by the Harvard Medical School Department of Psychiatry and the National Mental Illness Screening Project. Additional information explains to physicians how they can recognize depression and what options are available for further evaluation and treatment.

There are also educational brochures, a video for waiting rooms that shows how depression potentially occurs simultaneously with other physical illnesses, and mental health referral information.

Physicians who participate in the National Depression Screening Day may decide to make depression screening a part of their regular services, said Jan Holcomb, executive director of the Mental Health Association of Illinois, a partner in the national Campaign on Clinical Depression, of which the screening day is one part. The campaign can provide materials to do so, she said.

The CCD is a public education program of the National Mental Health Association designed to deliver hope and treatment to depression sufferers. Every year more than 17 million Americans suffer from some type of depressive illness, yet only one-third of those people seek treatment, Holcomb said.

One goal of the campaign is to show providers that, while easy to test for, depression often goes undiagnosed. It can manifest itself with several physical symptoms and can be masked by other physical illnesses.

A Harvard Medical School study conducted for the World Health Organization and the World Bank found depression topped the list of leading disability causes worldwide in 1990. People with conditions such as heart disease, stroke, cancer, diabetes, Alzheimer's and Parkinson's disease face an additional recovery obstacle if they're also depressed.

Sponsors of the screening day include the American Psychiatric Association, the American Academy of Physician Assistants, the American College of Obstetricians and Gynecologists, the American College of Physicians and the American Medical Association.

"The College has been concerned about the high proportion of those with depression who elude diagnosis, since depression is a debilitating disease that is eminently treatable," said ACP Senior Vice President Herbert Waxman, MD.

For more information about depression and to order screening materials, contact the MHA at (312) 368-9070. ■



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R EPORT for Illinois Physicians

ACUPUNCTURE

Acupuncture is the practice of piercing specific sites with needles. Acupuncture has been utilized for a variety of clinical indications. These indications have included:

- induction of surgical anesthesia
- relief of pain
- alleviation of withdrawal symptoms of substance abuse
- treatment of various non-painful disorders

"**Electroacupuncture**" refers to the attachment of wires to acupuncture needles to provide low voltage electrical energy. This electrical energy substitutes for the manual "Tweedling" of standard acupuncture. (Electroacupuncture is sometimes referred to as transcutaneous electrical nerve stimulation acupuncture or tens acupuncture).

There is great consumer demand for these services as evidenced by the out-of-pocket expenses incurred by those receiving acupuncture services.

Blue Cross Blue Shield must spend its limited resources carefully. Your interest and the interest of our members and corporate clients are only served if we limit benefit payments to those services that have been shown, through the scientific process, to be of clinical value. There are many alternative therapies, ranging from copper bracelets for arthritis to leatrile for malignancies. We would be derelict in our duties to all of our constituencies to pay for such treatment. As alternative therapies such as acupuncture, however, move a bit closer "acceptance" through widespread demand and availability, our task becomes daunting. The recent report by the National Institutes of Health (November 3-5, 1997) advanced the discussion by presenting a body of opinion regarding acupuncture, but scientific data documenting the effectiveness of acupuncture is not yet available.

For this reason, **acupuncture** or **electroacupuncture** in any form is still considered **investigative**. Controlled clinical studies to date have failed to show effectiveness for either acupuncture or electroacupuncture.

Ryan's run for top spot has roots in family pharmacy

REFORM PROPONENT:

GOP stalwart seeks fairness for Illinois physicians. BY ED FINKEL

From his early years as a pharmacist and small-businessman in his native Kankakee, Illinois Secretary of State George Ryan has dealt frequently with the concerns of the medical profession. As the GOP candidate running for governor, Ryan continues to lend a receptive ear to the health care community on issues such as managed care reform, tort reform, and rural health care.

Ryan said his background in pharmacy "gives me a better understanding of [health care] issues," despite health care having changed greatly since he was a practicing pharmacist. Ryan co-owned a chain of Kankakee pharmacies that was in his family for 43 years until the stores were sold in 1990.

Ryan's experience in health care gave him an insider's perspective, said Kankakee radiologist Donald Parkhurst, MD, an ISMS member and longtime Ryan friend and supporter. "He got to know our problems." While Ryan does not believe the law should be used to favor one side or the other, Dr. Parkhurst said, "he thinks things should be fair. He understands the patients' need for a bill of rights; he understands the doctors' need to be treated and paid fairly."

Ryan has vowed that, as governor, he will provide necessary leadership to ensure that as many Illinoisans as possible have the medical service they need. He proposes a comprehensive health care plan that includes a patient bill of rights aimed at strengthening consumers' position without letting health care inflation spiral upward. One provision in the plan would provide access to emergency treatment without prior approval. "In too many cases, doctors have to wait before finding out if someone with chest pains is having a heart attack or heartburn," Ryan said. "They have to wait for a faceless paper-pusher reading out of a managed care rule book to decide if the guy with the pain in his chest is covered or not."

Other components of Ryan's plan would:

- Allow for meaningful choice of primary and specialty care physicians, preserving a doctor's ability to make referrals. "Patients ought to have the right to pick their physician," Ryan said.
- Allow for patient appeals of HMO denials to an independent, unbiased review board.
- Forbid gag rules that ban physicians from discussing all treatment options.

Ryan was – and still is – a strong supporter of the 1995 tort reform law that placed a \$500,000 cap on non-economic damages. Signed into law by Gov. Jim Edgar, the law was ruled unconstitutional

by the state Supreme Court last year.

"Most states we usually compete with for business and industry – Florida, Texas, and even our neighboring Indiana – have caps on awards," Ryan said, in a recent speech to the Illinois Civil Justice League, a non-profit organization dedicated to reforming the state's civil justice system. "Here, business decisions will continue to be held hostage by worries about the cost of potential litigation, rather than what's best for Illinois and its people."

Before it was overturned, the law had cut product liability suits from 25 filed per week to four, Ryan noted. "Obviously, it was a pretty effective piece of legislation," he said. "Those reforms finally restored some balance to the areas of product liability, medical malpractice and liability for local governance. The system was becoming more manageable and more predictable for all parties. And now, we're back to the drawing board and we have to do it all over again."

How will they do it? "That'll be up to the General Assembly to come up with a revised law that would withstand Supreme Court review," Ryan answered in a recent interview. As governor, he said, he would work with legislators to get a tort-reform package passed, and he would gladly sign it when it crossed his desk.

To improve health care delivery across Illinois' vast rural areas, Ryan wants to expand telemedicine technology, which allows doctors and patients to communicate and transmit data electronically. He also supports financial perks that entice young doctors to rural areas, and he wants to investigate "a wider mix of incentives" to medical students, including college-loan repayment and public/private scholarship partnerships.

Secretary of State since 1991, Ryan's accomplishments include fighting for a law lowering the legal intoxication limit for motorists from a blood-alcohol con-



Illinois Secretary of State George Ryan campaigns for governor in the Naperville Labor Day Parade Sept. 7. Ryan proposes a comprehensive health care plan for Illinois.

Matt Ferguson

tent of .10 to .08 percent, and the "Life Goes On" organ donation program – a finalist in the prestigious Harvard University/Ford Foundation "Innovations in American Government" program.

Ryan also served as lieutenant governor under James R. Thompson from 1983-91, and he was a member of the Illinois House from 1973 to 1983, including House Speaker in his last term.

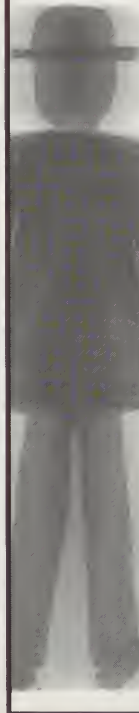
By mid-September, Ryan's campaign had built a comfortable, but not insurmountable, lead in most polls, as he spent the summer hammering away at Democratic nominee, U.S. Rep. Glenn Poshard's (D-Marion) record on gun control and the environment, among

other issues. Some conservative Republicans did not appreciate Ryan's attempts to outflank the relatively conservative Poshard on the left, by reaching out to traditionally Democratic groups.

But Dr. Parkhurst said Ryan is his own man. "It was pretty apparent early on that he is a guy who is loyal," Dr. Parkhurst said. "He doesn't change his opinions on the basis of a poll. His word is good. A lot of people in the medical community have always felt a close relationship with him." And Ryan remains accessible even now, he said. "When I call, when anyone from Kankakee calls, there are no formalities. You get right to him," Dr. Parkhurst said. ■

Murder At The Mall

Another in the "Doctor Solves A Mystery" Series from the PBT



I heard the flatfooted plop-plop of Lieutenant Lawson's feet coming down the hall long before he squeaked the hinges and entered into my reception area.

As a physician and private investigator, I knew Lawson wasn't here for a medical consultation.

"Hi, Doc," Lawson greeted.

"Heard you narrowed down the suspects to Ginger, Connie and Basil. Let's see what we can do with them, Doc." Lawson snickered as he parked his carcass on the Chesterfield in front of my gunmetal gray desk.

"As you know, Ginger and Connie both thought they were engaged to Wilkins." I replied. "Basil owns Harold's Haberdashery, a mall boutique in financial trouble. Basil's largest investor was Wilkins. If Wilkins didn't die for love, he died for money."

"Let me give you the scoop, on the murder weapon, Doc."

"What do you have, Lawson?"

"A stale loaf of bread, a day-old bagel and a wayward apple pie in a tin pie pan. Any one of these could have been used to crush a skull. Each suspect was carrying one of these the day of the

murder."

"Ok, so we've got three suspects and three possible weapons. What else do you know?"

"Let me check my notes, Doc. The suspect with the day-old bagel frequently goes shopping with Ginger. Basil was shopping with the suspect with the wayward apple pie. In fact, they were together in Sally's Shirt Shack at the time of the murder. Basil claimed to have seen the suspect with the day-old bagel wandering the mall the morning of the day the murder was committed."

"Your notes are screwy, Lawson, but they'll do. The murderer is..."

Who done it? Which weapon did the killer use? See the solution in this issue.

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EDITORIAL

Our brush with deunification – What now?

In the tradition of unity embedded deep in ISMS history, the House of Delegates has decided that the best way to solve the problems facing organized medicine is to stick together. During the debate, unification supporters relied several times on a quote borrowed from Benjamin Franklin, spoken July 4, 1776 at the signing of the Declaration of Independence – “We must hang together, or most assuredly we will hang separately” – to help make their case.

Although this is a victory for unification, it should not be interpreted as a mandate for the status quo. The 81-80 vote in favor of AMA deunification demonstrates that the number of delegates favoring and opposing unification is essentially equal. But, like amending the U.S. Constitution, changing ISMS bylaws is a grave matter; it takes more than a simple majority to approve amendments.

Decisions to reshape the institution's foundation require a two-thirds approval of delegates credentialed at the time of the vote. Although deunification clearly had strong support, it did not have the decisive two-thirds majority it needed to break with the long-standing unified tradition.

One argument favoring deunification is that it would make the AMA earn its membership, instead of having members

fall in its lap. But even coming this close to deunifying gives the AMA added incentive to better serve Illinois physicians. The issue of deunification has been coming up regularly and it is unlikely the vote at the special meeting will be the House's final consideration of this issue.

Our brush with deunification delivered a message to the AMA – it cannot take unity with ISMS for granted. In a plea for unification made to the HOD at the Sept. 19 special meeting, AMA Executive Vice President E. Ratcliffe (Andy) Anderson Jr., MD, said he has heard that message. He candidly admitted that there are problems at the AMA, which must be turned around.

He went so far as to guarantee that if the AMA was granted a second chance, he would not be back before the House one year later asking for another deunification delay. “We will let our actions speak for themselves.”

Illinois physicians should do the same. Use this extension of unification as a time to take your own actions – communicate to the AMA what you want it to do, get involved with ISMS and the AMA. Remember ISMS is the AMA. Anyone disappointed in the outcome of this decision should not just sit back and wait for change.

PRESIDENT'S LETTER

Unity vote gives AMA time requested to change its course

Richard A. Geline, MD



The outcome of the special House of Delegates meeting is now history. By the narrowest of margins, the resolution to drop our unified membership policy with the AMA and county medical societies achieved a majority vote – but it failed to win the two-thirds vote necessary for a bylaws change. Illinois thus remains one of four unified states left in the country.

The result was no doubt met with delight by some, disappointment by others and perhaps indifference by a few more. Further, some delegates may be planning to raise the issue again next April during the House's regular annual meeting.

More important than the result, however, were the messages delivered during the course of the debate. Regardless of their position on unification, virtually everyone who expressed their opinion agreed that physicians today need a strong voice and presence at the national level. The only question was whether this goal can be effectively achieved with the current unified structure, or is better pursued through new forms.

Those voicing opposition to the current format expressed three major themes:

- Cost of dues. Physician incomes are falling and doctors are looking for ways to save money. Allowing physicians to pick individually the organizations they join may be necessary to assure the strength of ISMS in the current environment.
- Disconnect from the AMA. Physicians seem to identify with their specialty societies more and more, and some of them see neither value nor benefit from AMA membership. The unification

requirement drives these members away from ISMS as well.

- “The Sunbeam affair.” While closed on the organizational level by action at the last AMA House meeting, the matter remains open in the minds of some physicians.

Those supporting the current structure spoke of the advantages and strengths of a bigger AMA, the 10 percent discount on AMA dues enjoyed thanks to unification and the potential weakening of Illinois' AMA representation should deunification occur.

They also said it was time to put the Sunbeam matter behind us, and that deunification at this time would send the wrong message to nonmembers. At the very moment when strength and unity are needed, they said, a message of discontent, separation and fragmentation can only be counterproductive to our cause.

Finally, and perhaps most important, was the message from the new AMA executive vice president E. Ratcliffe (Andy) Anderson, Jr., MD. He likened the AMA to a battleship changing course, saying the organization is transforming, not sinking. “We are not the Titanic.”

Admitting some of the problems of the past, and touching on how he's trying to address the challenges of the future, Dr.

Anderson spoke of the need for a full-scale culture change at the AMA, beginning with a new responsiveness to the membership's priorities. Dr. Anderson – in office only since June – asked our House members for more time to bring about the changes.

He got the time he asked for. Let's see what happens.

*Regardless of
their position on
unification, everyone ...
agreed that physicians
today need a strong
voice and presence at the
national level.*

GUEST EDITORIAL

The choice is ours – Ethical actions under managed care

By Lee S. Anderson, MD

In the movie *The Rainmaker*, a young lawyer peers across a table at a perfectly coifed older attorney and asks, "How old were you when you sold out?" Could that declaration apply to us, fellow physicians?

Have our responsibilities to patients changed in managed care? I don't think so. But what seems to have changed for some physicians is a passion for ethical behavior in the midst of managed care's restrictions.

It is we physicians who are either ethical or unethical in managed care, and only we enable a business to continue its unethical behavior patterns. The search for ethics in managed care continuously returns to doing what is right for patients. Our advocacy role should extend beyond insisting on quality in hospitals and in home health care; we should also explain truthfully to our patients specifically what often goes on in managed care.

"Who will be left to take care of sick people?"

Consider the following questions:

- "I think you'll get better care from Dr. X, rather than Dr. Y, whom you've been seeing for the last five years." Or, "Your doctor is not on the plan anymore." Are patients being steered to specific specialists because of "management fees" between primary care physician groups and specialist groups? Who is reluctant to tell patients the truth?

- "This drug for hypercholesterolemia will work just as well as Lopid." Or, "I think you'll be okay with cholesterol in the mid-200s." Are patients being effectively denied medically necessary care because of pharmacy budgets?

- "Even though you have diabetes, arteriosclerotic cardiovascular disease, and marginal end-stage renal failure, and live 100 miles from here, I feel we can safely do your surgery under general anesthesia as an outpatient." Is saving money worth this kind of risk? Is this good medicine or is it what-can-we-get-away-with medicine?

- "Fee-for-service medicine is more ethical than capitation." Perhaps it is, but can you remember the risk to patients for overprescribing and performing unnecessary surgeries in fee-for-service medicine? Were we all ethical then and not now, simply because of a different payment mechanism?

As naive as it may sound, ethics in managed care starts and stays with physicians. Yes, some health care plans may be unethical by their corporate culture, but who empowers such behavior? Who looks the other way? Who doesn't speak up? Who joins the "brotherhood of silence"? Who rationalizes 100 excuses to allow unethical behavior to continue? Who feels

gagged because they fear economic isolation and losing access to patients? Who retires rather than resists? Who does all the "go-go" medicine and surgery to avoid this problem? And lastly, who will

be left to take care of sick people?

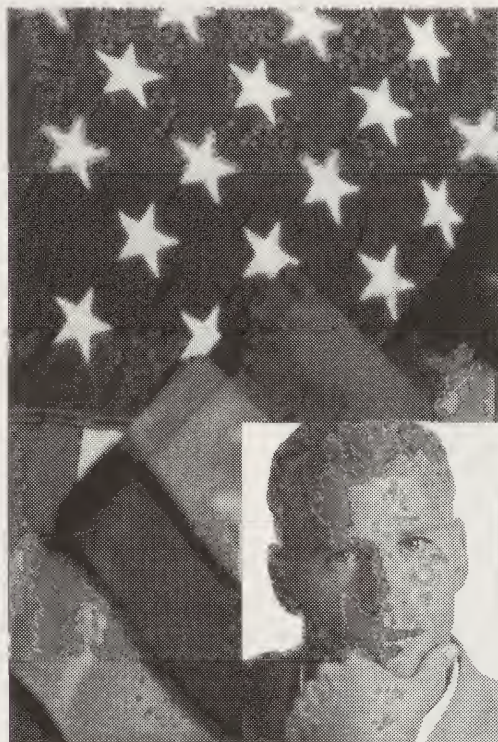
As physicians, we are the only ones in this system who hold a duty to be ethical. And it is ultimately we who must look in our mirrors every day and like what we see for the right reasons. To me, upholding ethics in medicine is as simple as the golden rule: Do unto others as you would have them do unto you. Some of us have rationalized that "he who holds the gold, rules," and this attitude has promoted a pervasive spirit of hopelessness and inaction in medicine.

I am not saying that managed care is either good or bad, but if you are misled into a situation you don't like, it's not

too late to rise up and change things, or get off the plan. My ophthalmology chief used to say, "Do the right thing . . . your patients will love you, and your colleagues will be amazed!" We, individually, have a duty to ourselves and to our patients to be ethical physicians. Clearly, the choice is ours.

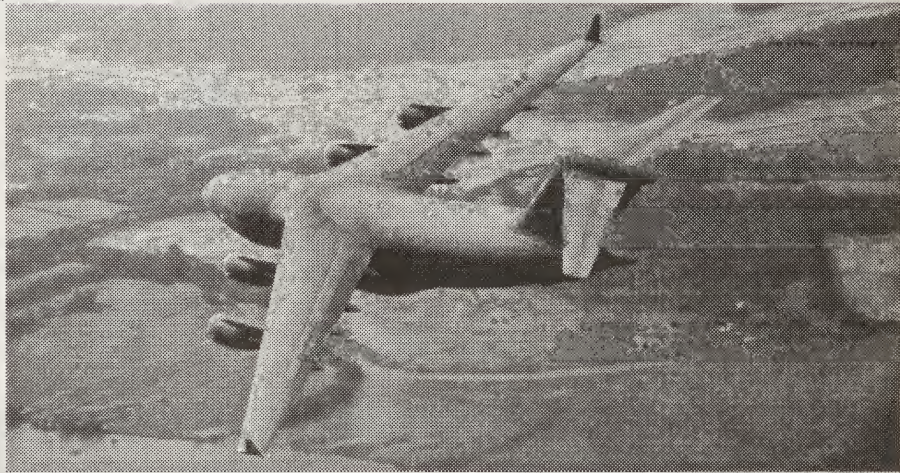
Lee S. Anderson, MD, is a Fort Worth ophthalmologist and immediate past president of the Tarrant County (Texas) Medical Society.

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Illinois' .08 law drives traffic-death drop

DRUNKEN DRIVERS: ISMS backed reduction of illegal blood alcohol level. BY JANE ZENTMYER

[CHICAGO] Illinois' alcohol-related crash fatalities dropped a record 11.6 percent in 1997 because of a law enacted last year that lowered the state's illegal blood alcohol content to .08, a measure ISMS strongly backed.

"The law is working just as we hoped," Secretary of State George Ryan said last month during a formal release of the statistics at Chicago's State of Illinois Building. "The experts told us if we lowered the blood alcohol limit to .08, we could expect to reduce the drunk driving death toll by at least 10 percent and save as many as 65 lives. Last year we saved 77 lives with .08 in effect for only half a year."

In 1997, 587 people died on Illinois highways as a result of alcohol-related

automobile crashes – an 11.6 percent decrease from 664 deaths in 1996. Traffic fatalities decreased 5.5 percent overall in 1997, with 94 percent of that decline linked to the drop in alcohol-related crash fatalities.

The .08 law also propelled Illinois beyond other statistical milestones, Ryan said. Last year was the first year since the state began compiling DUI statistics that the Illinois tally fell below 600 alcohol-related crash fatalities. And, alcohol-related traffic deaths accounted for 42.1 percent of total automobile crash fatalities – another record low.

Based on policy the ISMS House of Delegates adopted in 1996, the Society strongly supported the law that made it illegal for anyone to drive with a blood

alcohol content of .08 or more, a reduction from the previous .10 limit. Illinois is one of only 15 states that has enacted a .08 law.

Tighter enforcement of existing laws and the ongoing push to curb drunken driving will help continue to reduce alcohol-related traffic injuries and deaths, said James Kelly, MD, director of the brain injury program at the Rehabilitation Institute of Chicago. The .08 law is a significant step in the right direction.

"The effectiveness of this needs to be widely publicized," said Kelly, who testified in favor of a .08 law before a state Senate committee. "Physicians should continue to instruct patients and family members about the dangers of drunken driving."

Studies have shown that a .08 law

works best when coupled with strong public-education efforts, Ryan said. Last year the state put up permanent road signs to warn motorists of the .08 law as part of its "A Safer State with .08" campaign. To remind drinkers to appoint a designated driver, Ryan's office also launched a program that distributed window stickers and drink coasters bearing the slogan, "If you're drinking, who's driving?"

"Last year we saved 77 lives with .08 in effect for only half a year."

George Ryan
Illinois Secretary of State

Illinois' record year mirrors a national trend. In 1997, alcohol-related crash fatalities dropped to an historic low of 38.6 percent of all the country's traffic deaths, the U.S. Department of Transportation announced in August. In 1996, 40.9 percent of the country's traffic deaths were linked to alcohol-related crashes.

"A strong message and tough laws are bringing about an important change in society's attitudes toward drunken driving, but we must continue our efforts to reduce the number of these tragedies even further," said DOT secretary Rodney Slater.

Illinois has also worked to decrease drinking and driving among teens. Under the zero tolerance law, drivers under the age of 21 who have any trace of alcohol in their system will lose their driving privileges. Since the law's Jan. 1, 1995, effective date, more than 9,000 Illinois teens have had their licenses suspended for driving under the influence, according to the secretary of state's office.

Between 1994 and 1997, the number of underage drunken driving arrests rose 134 percent while the number of licensed drivers ages 15-20 increased only 6 percent. Alcohol-related fatalities among teens dropped 19.6 percent when comparing 1994 (pre-zero tolerance) statistics to 1996.

HMO complaints skyrocket in Illinois

The number of complaints against HMOs received by the state of Illinois from consumers soared 54 percent in 1997, compared to the previous year.

According to recently released data from the Illinois Department of Insurance, the agency received just short of 400 more calls last year than it did in 1996. The number of calls in 1997 topped 1,100.

A department statement indicated that claims handling continued to account for the majority of complaints against HMOs. Claims-handling complaints, it explained, ranged from payment delays to outright denial of a claim.

"For HMOs," the statement noted, "recent women's health care initiatives, such as minimum maternity stays, post-mastectomy hospitalization and designation of an Ob/Gyn as a women's principal health care provider, generated numerous inquiries and written complaints."

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ISMIE Update

Coming soon:
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Avoiding sexual misconduct allegations

Effective risk management includes strong communication skills and a chaperone.

BY JANE ZENTMYER

Richard Wolke, MD, was examining his fifth patient on a Tuesday morning when a police officer appeared with an arrest warrant. "Come downtown," the officer told Dr. Wolke. "A patient has filed sexual misconduct charges against you. We have questions that need answers."

At police headquarters, Dr. Wolke was urged to cooperate with police and to answer any questions. A thoroughly intimidated Dr. Wolke hesitantly agreed, setting in motion a legal process that threatened to ruin his career.

Although this story is hypothetical, situations like this actually have occurred to innocent Illinois physicians. Often they are surprised to discover a patient has misinterpreted a legitimate examination procedure as inappropriate sexual action and has filed a complaint against them. Joe Camarra, an attorney and partner at Cassidy, Schade & Gloor in Chicago, said accused physicians can face serious consequences – criminal charges, a civil action, possible loss of insurance coverage for

the civil case, disciplinary action by IDPR and the destruction of their reputation.

Risk management can help physicians prevent sexual misconduct allegations. Physicians must first understand that they cannot predict which patients are prone to making these claims, Camarra said. They must set aside the assumption that no one will ever accuse them of wrongdoing, he said.

Most sexual misconduct charges are filed by female patients against male physicians, Camarra said, but a few cases have involved male patients and female physicians. Allegations can be levied against physicians of any specialty – Ob/Gyns, psychiatrists, family physicians. Even pediatricians could find themselves in trouble if a child makes such a claim to his parents, Camarra said.

To protect themselves, physicians should have another person, such as a nurse or an assistant, present in the room during an exam as a chaperone, Camarra said. Unfounded sexual misconduct claims are more difficult to make if a third party witnesses the exam in question.

Pedro Poma, MD, an Ob/Gyn at Ravenswood Hospital Medical Center in Chicago, said many of his patients expect to be asked if they would like a female assistant present during the exam, and most react positively. "A few women choose to



Illustration by Linda Bleck

have nobody else in the examining room because they feel it affects their privacy," Dr. Poma said. "In those situations, physicians should document the patient's refusal."

Good communication during the exam is essential, added Dr. Poma. Each step of an exam should be explained to the patient, he said, as well as why tests, such as a pap smear, are necessary, and when and how the patient can get the results. Dr. Poma said, "This 'why and how' explanation helps ease the patient's concerns about being examined."

Chart your visits thoroughly, Camarra also advised. He recalled one physician who failed to document the reason for a patient's pelvic exam – to check on a pelvic infection. When the female patient alleged sexual misconduct, Camarra said the incomplete medical records hurt the physician's defense.

A study published in the 1998 Journal of the American Medical Association found that the number of physicians disciplined per year for sex-related offenses increased from 42 in 1989 to 147 in 1996. Discipline is more severe for sex-related offenses than for other violations of states' physician practice acts, with almost 72 percent involving revocation, surrender or suspension of medical licenses.

IDPR commonly hears about sexual misconduct charges from patients or their families, or from police agencies, said Andrew Gorchynsky, MD, IDPR's chief medical coordinator. "The department is very sensitive to allegations of sexual misconduct," he said. IDPR will investigate to see if accused physicians have previous complaints of a similar nature against them, and sometimes will run a criminal background check.

In many cases, the physician didn't have a third party in the room, and the case becomes "he said, she said," according to Dr. Gorchynsky. If it appears

the patient misinterpreted an exam, Dr. Gorchynsky said the Medical Disciplinary Board may instruct him, as chief medical coordinator, to write the physician a letter explaining that the investigation didn't find a Medical Practice Act violation. However, he will express the board's concerns and offer suggestions to prevent future charges. If the board disciplines the physician, it can pick from a number of actions, including revocation and suspension.

Physicians should avoid personal relationships with their patients, said Dale Austin, the Federation of State Medical Boards' deputy executive vice president. "Those relationships, if they become sexual relationships, can be a problem for physicians," he said. "The physician-patient relationship is one in which physicians cannot have it seem as if they're taking advantage of that unique relationship for sexual gain."

Physicians who find themselves embroiled in a criminal case should remember their legal rights to representation, Camarra said. They don't have to answer questions without an attorney present – no matter what a government official or state prosecutor says. Camarra said physicians in this scenario should use an attorney who specializes in criminal work, and "should hire that person before making statements." ■

MALPRACTICE ROUNDUP

Overaggressive surgery costs New Jersey physician \$1 million

A plaintiff alleging that overaggressive surgery for thyroid cancer caused permanent disabilities has been awarded \$1.02 million by a New Jersey jury.

According to the August 1998 issue of Medical Malpractice Law & Strategy, the plaintiff argued that a thyroidectomy to treat his thyroid cancer deviated from the standard of care. The radical neck surgery left the patient with impaired mobility in his right arm, he claimed.

The defendant countered by claiming that he had first done a partial thyroidectomy and moved to the more radical procedure after lab tests showed evidence of cancer in the excised tissue. He said that he had acted within the standard of care because there was a danger of metastasis. The jury failed to agree.

Physicians found liable in Ohio failure-to-diagnose embolism case

Three physicians must pay \$1.4 million to the widow of a man who died of a pulmonary embolism. In *Sever vs. Lake Hospital System*, as reported in the August 1998 issue of Medical Malpractice Law & Strategy, a Cleveland jury sided with the plaintiff, who claimed the hospital and its physicians had been negligent in not performing an angiogram or a CT scan on the decedent.

The plaintiff said that such tests would have detected the embolism, and that it could have been treated. The jury found the defendant physicians negligent in not performing the appropriate tests – ordering them to pay the \$1.4 million – but found the hospital not liable.

MD

CONFIDENTIAL

The pitfalls of protecting patient privacy

BY KAREN TITUS

When it comes to protecting the privacy of patient records, physicians would do well to keep an eye on the forest as well as the trees.

On a broad level, patients, Congress and security experts have voiced fears that confidential medical information is vulnerable to privacy breaches. The advent of electronic medical records and huge insurance databases, and the growth of managed care and integrated health care networks have fueled this concern.

Closer to home, physicians should be aware of small security gaps that may exist in their own office practices. Among the biggest hazards are those likely to be overlooked, such as paper records and low-tech communication methods.

And, amid these large- and small-scale problems, physicians should be aware of the liability issues surrounding patient privacy. Generally, Illinois law makes it fairly clear that all patient medical information is to remain confidential, unless consent for release is given by the patient, a court order or a public health concern, said Chicago attorney Tom Conley, a health care law expert.

Fortunately for physicians, while the potential for problems seems broad, in reality actual privacy breaches appear to be few.

If anyone is infringing on patient privacy, he noted, it may be patients themselves, who agree to forgo privacy rights with greater frequency, often via release agreements signed with their managed care plans.

Medical privacy has attracted the attention of national leaders, who have begun to react. In June, the Clinton Administration toughened Medicare rules by requiring health plans to protect medical records and forbidding plans to sell members' names and addresses.

Federal legislation regarding privacy is expected to emerge within the next two years. The Health Insurance Portability and Accountability Act of 1996 requires either Congress to enact privacy legislation by August 1999 or the secretary of the U.S. Department of Health and Human Services to produce privacy regulations by January 2000. HHS recently unveiled new proposed standards for protecting individual health information maintained or transmitted elec-

tronically. A handful of congressional proposals, such as various patients bills of rights, as well as a presidential advisory commission, also target medical record security and patient confidentiality.

Until federal guidance becomes available, however, physicians must rely on state law – and common sense – to sort through privacy issues.

The delicate balance between privacy and public health has often been an issue confronted by policymakers. Currently, the names of those Illinoisans afflicted with 60 different infectious diseases – including syphilis, tuberculosis and AIDS – are reported to the Illinois Department of Public Health. Such disclosure, health officials say, leads to improved clinical assessments, research and containment.

Striking that balance has not always been easy, especially with sexually transmitted diseases that carry a real or perceived stigma. Privacy advocates have fought against any threat to confidentiality, saying they want to protect these patients against discriminatory backlash.

IDPH, however, points to its record on AIDS as proof of its ability to pull off the balancing act. Since 1981, IDPH has recorded the names of over 20,000 persons with AIDS, and, it says, its confidentiality has never been breached. So successful has it been, in fact, that the department has proposed expanding the names-reporting to anyone testing HIV-positive.

ISMS is on the record supporting HIV name-disclosure. At an IDPH public hearing held this spring, ISMS President Richard Geline, MD, stated that reporting names would help ensure early intervention, as well as prevention of the deadly disease.

However, Dr. Geline added that, because it was important to respect patients' rights and protect their confidentiality, the Society did not back the proposal "until we could secure improvements to the confidentiality provisions in Illinois statutes that prohibit discovery of these records in civil actions."

Lawrence Gostin, a professor of law and public health at Georgetown and Johns Hopkins universities, who chaired a Centers for Disease Control and Prevention study examining state public health information privacy laws, said that when it comes to medical information, "we are putting two

important values against each other."

One is the social value of using medical information. "We do better clinical assessments, we do better research, we achieve better public health results and we can cut costs," Gostin explained. The other issue is personal privacy. "It's not easy to strike a fair balance between the two and maintain patients' trust," he said.

Despite those frustrations, Richard Sperling, MD, a Skokie-based plastic and reconstructive surgeon,

Physicians must rely on state law – and common sense – to sort through privacy issues.

draws a clear line when it comes to protecting patient privacy. "When a patient comes to you, that patient deserves confidentiality, even with regard to their own family," he said. "Legally we're not allowed to give out any information without patient consent."

This can mean awkward moments for physicians, he admitted. "We'll get calls from the grown children of a patient, asking what is happening with their parent, what tests have been done, and so forth. Even though the request is from a family member, many times a parent does not want the information transferred to the children, or any relatives."

Other conflicts occur with insurance companies, he said. "We'll frequently get calls from insurers, saying, 'I'm from XYZ Company, and I'd like to know what was done on this patient,'" Dr. Sperling said. "Our office tells them, 'I'm sorry, but without the written release of that patient, we cannot provide you with any information.' You have to take a hard and fast stance on this."

Just as important, say experts, is making sure medical records are safeguarded within an office.

Dr. Sperling said the place most vulnerable to information breaches is the waiting area, where patients can easily overhear staff discussing other patients. Faxes are also a weak spot in the security wall; there's basically no such thing as privacy when you send a fax. "I mail instead of fax unless it's urgent to send something immediately," Dr. Sperling said.

The advent of electronic medical records, especially within large managed care organizations, creates other potential problems. While EMRs may permit better patient care by providing physicians with quick access to comprehensive patient data, it's not always clear how well this information is protected. Biometric means of identification, like fingerprint scans, facial and voice recognition, and retinal scans, as well as wireless tokens and smart cards, may advance the case of patient privacy. But, experts say, no method will be totally secure.

Given the ever-changing environment, how can physicians stay on top of privacy issues? As a legal expert, Conley suggested a continual audit initiative as medical processes and technology evolve. "Physicians should continually review their office policies and procedures, and make sure there are confidentiality checks in place," he said. Just as important, he added, is to train new staff to follow those procedures and to remind current staff of their importance.

"Guarding privacy is critical," he concluded. "Don't ever forget that. If you do, there could be consequences for everyone." ■

A privacy checklist

Privacy specialists urge physicians to take steps to make it harder for prying eyes to view private information:

- ✓ Verify the identity of anyone requesting medical information.
- ✓ Keep computer passwords private.
- ✓ When transmitting patient records online, make sure to encrypt the information, and ensure the recipient has security measures in place.
- ✓ Verify authorization when sharing data.
- ✓ When faxing results outside the office or making photocopies, be sure to remove papers from the fax machine or copier promptly.
- ✓ When discarding papers containing private patient information, shred the documents before putting them in the trash.
- ✓ Turn desktop computer monitors at an angle to prevent passersby from viewing the screen display.
- ✓ Hold regular staff meetings to discuss security-related topics and concerns.
- ✓ Link staff performance reviews to adherence to security practices.
- ✓ Clearly spell out the repercussions of failing to follow security procedures; disciplinary actions should be fast, fair and consistent.
- ✓ Consider using an outside specialist to assess your office's security practices.

IDPR DISCIPLINES

This information, published as space permits, is reprinted from the Illinois Department of Professional Regulation's monthly disciplinary report. IDPR is solely responsible for its content.

April 1998

Edmund Ringus, Chicago – physician and surgeon license reprimanded for failing to monitor the use of his signature stamp by an entity to which he provided radiological services with regard to billing, payment drafts, and execution of physician's liens.

Gregory A. Schierer, Aurora – physician and surgeon license reprimanded and fined \$3,500 for failing to inform his patient of an injury that occurred during surgery and his attempt to repair the problem, and failing to document the incident in his surgical report.

May 1998

Kirit J. Bhatt, Chicago – physician and surgeon license reprimanded and fined \$1,000 for failing to return telephone calls and failing to provide medical records.

Terrold Butler, Chicago – physician and surgeon license placed on indefinite probation due to outstanding income tax liability owed the Illinois Department of Revenue.

Willard J. Eyer, Olney – controlled substance license restored on probation for two years.

Carla B. Greby, Kewanee – physician and surgeon and controlled substance licenses placed on indefinite probation for non-therapeutically prescribing nar-

cotic analgesics to patients who became addicted to codeine, and failing to make and maintain controlled substance dispensing logs for samples dispensed as required by law.

Rafael Guerra, Westmont – physician and surgeon license indefinitely suspended for failing to diagnose and treat stomach cancer of a patient.

Gautam Gupta, Rockford – physician and surgeon and controlled substance licenses placed on probation for one year for failing to properly apprise female patients of the procedures required in heart and lung examinations, and not being aware of inventory and record keeping requirements regarding dispensing of controlled substances.

George Y. London, River Forest – physician and surgeon license placed on probation for one year for providing excessive postoperative care to a minor child following an appendectomy.

Isaias D. Sunga, Tinley Park – physician and surgeon and controlled substance licenses placed on probation for one year effective as of end of current period of probation and fined \$500 for violating the terms and conditions of a previous Department order.

William Woodruff, Aurora – physician and surgeon license reprimanded and fined \$1,000 for failing to implement adequate monitoring and delivery procedures in the case of a stillborn infant.

Mario Arce Zapata, Aurora – physician and surgeon license placed on probation for one year due to unprofessional conduct of a sexual nature during an examination of a female patient.

June 1998

Mohammed J. Ali, Willowbrook – physician and surgeon and controlled substance licenses indefinitely suspended due to lack of verification of passing the SPEX examination, a condition of probation set forth in a previous Department order.

Stephanie Bekker, Chicago – physician and surgeon license reprimanded for failure to secure a current X-ray before providing a patient with a release to go to work.

Carmon Dunigan, Chicago – physician and surgeon license indefinitely suspended due to outstanding tax liability owed the Illinois Department of Revenue and failure to file Illinois income tax returns for the years 1986-1996.

David A. Fitzgerald, Escanaba, Mich. – physician and surgeon license indefinitely suspended due to outstanding tax liability owed the Illinois Department of Revenue for the years 1988-1995.

Joseph Giacchino, Melrose Park – controlled substance license restored on probation for two years.

Charles Kuhn, Peoria – physician and surgeon license indefinitely suspended due to impairment caused by an accident in which he suffered a serious head injury.

Richard C. W. Steinberg, Arlington Heights – physician and surgeon license placed on probation for two years for receiving money to furnish medical records and failing to furnish them, failure to provide medical records in a timely manner, and failure to follow up on an examination due to lack of communication with a patient. ■

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SOME THINGS
don't.

Physicians' group takes on managed care

[CHICAGO] A Chicago physicians' group has banded with the Rev. Jesse Jackson Sr. and the Rainbow/Push Coalition to fight what they said are the discriminatory managed care tactics of United HealthCare of Illinois Inc.

"We are deeply concerned about managed care and how managed care affects the way we practice medicine and how it affects our patients," Ronald Hickombottom, MD, president of the Chicagoland Physicians Association, said during an August news conference at PUSH headquarters, 930 E. 50th St. The organization represents about 200 physicians - many African-American, Hispanic, Indian and Asian. Its stated purpose is to expose how the policies and practices of United HealthCare are running them out of business and

eroding medical care for urban poor.

"We will no longer stand by quietly and allow HMOs like United to use their unfair, unjust and immoral practices against physicians and innocent patients," Dr. Hickombottom said.

Jackson charged that the Chicago-based United HealthCare drives black and brown physicians into bankruptcy, inconveniences and neglects poor patients, delays some cancer-screening tests, harms the doctor/patient relationship and shifts medical decisions from physicians to corporate executives. "Our doctors have decided to fight back," Jackson said.

United HealthCare denied the group's charges. A spokesman previously responded to similar claims by saying that the company's relationship with the physician community is solid. ■

Parkinson's patients sought for drug study at SIU

The Southern Illinois University School of Medicine in Springfield is seeking participants in an international drug-combination study aimed at Parkinson's disease patients.

Talcapone will be used in the study in combination with levodopa, a drug used to help the dying brain cells of Parkinson's patients produce the chemical dopamine. Following several years of levodopa treatment, there will be fluctu-

ations in the response to the treatment. Initial studies suggest Talcapone may delay the onset of these fluctuations.

To be eligible for the study, volunteers should be between the ages of 30 and 75, should not have taken levodopa preparations for more than a week and should be willing to come to SIU's Parkinson's Disease and Movement Disorders Clinic in Springfield for periodic examinations over five years. Participants will receive examinations, laboratory tests and the study medication at no charge.

Interested patients or their physicians should call (217) 785-8684. ■



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Peoria County delegate Stephen Smart, MD, makes his case in favor of deunification.

ISMS rejects

(Continued from page 1)

ed out Edward Warren, MD, a Vermillion County delegate. If this body is going to do its job and represent its grass-root physicians, "then we must vote to deunify," Dr. Warren said.

But other physicians refuted the survey, calling it "completely biased." For example, they angrily noted that the survey failed to include the opinions of emeritus and retired physicians. Emeritus and retired physicians were excluded from the survey because they are not dues-paying members and are not among the groups canceling their memberships.

The Society has used Coldwater Corp. surveys for many years and this is the first time Coldwater's credibility has been challenged.

Deunification would weaken the AMA, opponents of the proposal said. "Our

specialty societies will not represent us as well in Washington. They do not have the voice of the AMA," said Harold Goodman, MD, a Cook County delegate.

The committee noted that many physicians decried the high cost of dues mandated by membership in three organizations. Physicians in the ten largest county medical societies pay an average of \$1,255 annually – \$420 to the AMA, \$500 to ISMS and between \$200 and \$550 to their county medical society.

But dues cost isn't an issue, deunification opponents said. The AMA dues of \$420 is about the cost of 10 neckties over the course of a year, said Kenneth Printen, MD, an ISMS 3rd District trustee.

The levels of organized medicine need each other to accomplish their goals, one physician stated. "I don't really have an option to join the national government. I don't have an option on which government I pay dues or taxes to," said James Andersen, MD, an ISMS past president and Cook County delegate, who concluded "the same thing should be true for medicine. When you join organized medicine, you don't join a fractionated organization."

Deunification supporters responded that physicians in 46 other states have the freedom to choose which organizations they want to join, and Illinois should be no different. "At 36 years of age, I consider myself one of those relatively young physicians. And I was quite shocked to be forced and not have a choice to join all three organizations," said Peoria County delegate Stephen Smart, MD. "Over 90 percent of the states are not unified. Over 90 percent. I believe it is a bit unreasonable and maybe even arrogant for the physicians of the state of Illinois to think that a decision to deunify would be the destruction of the American Medical Association."

"Let this be a wake-up call to the AMA," said Ramaraja Yalavarthi, MD, a Cook County delegate, who added that competition is the essence of U.S. society. "Let the association prove that it's worth my membership dues."

E. Ratcliffe (Andy) Anderson Jr, MD, the AMA's executive vice president, said the organization has projects underway to improve its delivery of physician services. They include creating a new office of member communications, putting the Sunbeam incident to rest, and consolidating all telephone banks and referral resources to ensure members' questions are answered efficiently and courteously.

Dr. Anderson asked that when delegates returned home to explain their vote against deunification they say they did it to give the AMA a chance to reform itself. "If you can do that – then I promise you – I guarantee you – one year from now, I will not be back to this House," he said. "I will not ask you again to halt or delay deunification. We will let our actions speak for themselves. And I will respect whatever decision you make."

Once the vote was taken, there was still indication that delegates had not heard the last of deunification. One delegate spoke in favor of redoing the study, with questions limited to deunification. There was also mention that deunification could be raised again at the HOD's annual meeting in April. In the meantime, Sangamon County delegate Howard Chodash, MD, said delegates should be careful to inform – not enrage – their constituents about the decision. ■



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Murder At The Mall

Solution (See mystery elsewhere in this issue.)

There are three suspects: Ginger, Connie and Basil. Likewise, there are three possible murder weapons: a stale loaf of bread, a day-old bagel and a wayward apple pie in a tin pie pan. Each of the suspects was carrying one of the possible weapons.

Lawson's notes provide the key to solving the mystery. His first note states: "The suspect with the day-old bagel frequently goes shopping with Ginger." This tells us that Ginger was not the suspect carrying the day-old bagel. She was carrying either the stale loaf of bread or the wayward apple pie. The bagel was carried by Connie or Basil.

Lawson's next note states: "Basil was shopping with the suspect with the wayward apple pie. In fact, they were together in Sally's Shirt Shack at the time of the murder." Basil did not commit the crime. He has an alibi as does the suspect with the wayward apple pie. Obviously Basil was not carrying the apple pie since the unidentified suspect with him was carrying it. Either Ginger or Connie was carrying the wayward apple pie.

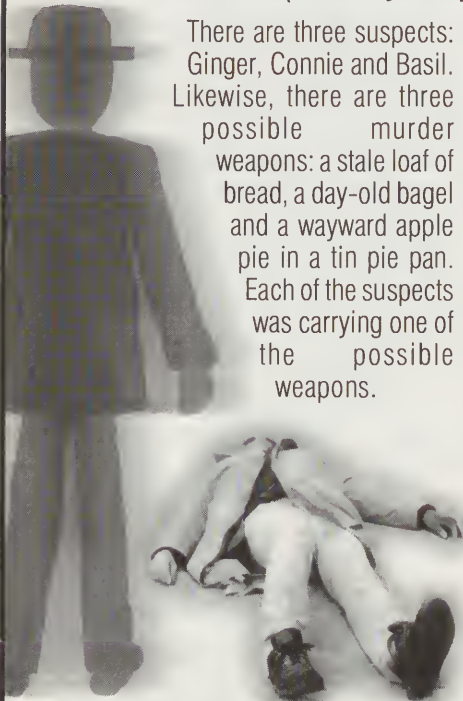
The third note states: "Basil claimed to

have seen the suspect with the day-old bagel wandering the mall the morning of the day the murder was committed." Basil was not carrying the day-old bagel. Based on Lawson's first note, Basil was not carrying the apple pie. He was carrying the bread. Obviously, Ginger and Connie were not carrying the bread. Since Lawson's first note told us that Ginger was also not carrying the bagel, she must have been carrying the apple pie. That means Connie must have been carrying the bagel. Lawson's second note informed us that the person carrying the apple pie was innocent as was Basil. Since Ginger was carrying the apple pie, Connie must be the murderer. The murder weapon was the day-old bagel she carried.

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ISMS, counties retain membership ties

Once the ISMS House of Delegates decided to remain unified with the AMA, they overwhelmingly voted to retain their unified status with the county medical societies as well.

"I believe it would be foolhardy to try to separate the counties from the state," said Morgan Meyer, MD, an ISMS past president and a DuPage County delegate. "We need to have a strong ISMS in Springfield."

"We have a responsibility to take a look at the different levels of our membership and to work together as closely as we can," added Janis Orlowski, MD, secretary-treasurer of the ISMS Board of

Trustees. If the AMA has failed physicians, she said, everyone can accept responsibility. "We have work to do. We have to reopen our communications with the AMA and work closely with ISMS and our county medical societies."

The delegates' action on county-state membership unification at a special HOD meeting Sept. 19 mirrors the recommendation of the Special Committee to Study Deunification, which recommended against deunifying from the county medical societies because little testimony and factual support was given to justify such a move.



Special committee Vice Chairman Steven Malkin, MD, (left) and Chairman Randall Mullin, MD.

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Biochip pact to speed genetic decoding

Genetic decoding completed one thousand times faster than currently done will be the result of a joint-research project recently announced by Motorola Inc., Packard Instruments Co. and the U.S. Department of Energy's Argonne National Laboratory.

The project, designed to commercialize and market biochips and related analytical technologies, will have myriad applications, including medical diagnostics and drug discovery.

Medical diagnostics should experience the greatest impact, according to a statement from the Argonne Lab. Medical and biological researchers will be able to identify in minutes mutated genes that could lead to later medical problems, like cancer, multiple sclerosis or Alzheimer's.

Physicians will also be able to predict drug efficacy, diagnose drug resistance and make on-the-spot identification of specific bacteria, viruses and other microorganisms. The lab also predicted an increase in the speed of the drug-approval process by classifying patient populations based on genetic makeup.

The biochips should also result in faster and more effective environmental restoration and improved agricultural products. ■



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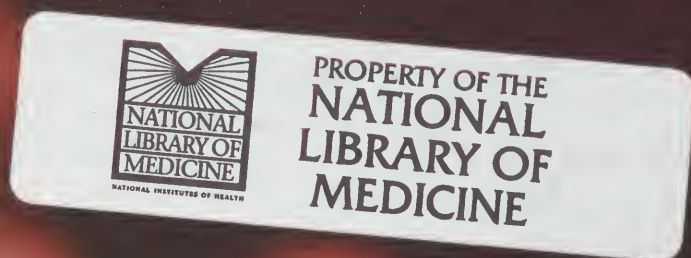
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Illinois Medicine

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Illinois
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PAGE 3

Controversial E&M rewrite underway

MOVING AHEAD: HCFA keeps checklist system.

BY JANE ZENTMYER

Despite protests from organized medicine, the U.S. Health Care Financing Administration plans to use a checklist-type system in its latest revision of E&M documentation guidelines, an approach that has infuriated grass-roots physicians.

"HCFA has decided some counting is necessary to assure consistent interpretation of the guidelines by Medicare carriers," explained Robert Berenson, MD, director of HCFA's Center for Health Plans and Providers, in a Sept. 22 statement. The American Medical Association has voiced its strong opposition to the use of counting or numerical formulas.

E&M documentation guide-

lines are government paperwork requirements physicians must follow to justify Medicare bills. E&M – evaluation and management – services are part of office visits for new and established patients, and other similar patient visits.

The 1997 revision – which has been on hold due to physician complaints – incorporates changes to requirements for documenting history and general multisystem exams, and introduces requirements for single-organ exams.

Critics say the requirements are time-consuming and stray too far from their original purpose – documenting patient information.

ISMS has been in the forefront of the drive to make E&M guidelines more workable for physicians.

"We will continue to monitor this situation and press for changes," ISMS President Richard Geline, MD, vowed in response to HCFA's refusal to drop the guidelines' quantitative aspects.

At the AMA's House of Delegates meeting in June, physicians from several state medical

societies, including ISMS, called upon the AMA to "oppose any documentation system that requires quantitative formulas or assigns numeric values to elements in the medical record."

The 1997 proposed docu-

mentation guidelines presented at the June meeting were based on this undesirable approach. For example, a detailed exam – one of four exam types – would have required paperwork documenting that between 12 and 17 services were performed.

"Any type of record format is acceptable, including simple
(Continued on page 10)



Catchpenny Productions

Millikin University student Andrea Durham examines Regional Organ Bank of Illinois materials at a Sept. 17 health fair in Decatur. (See related story, page 7.)

State opts for HIV number reporting

TRIAL-RUN: Test would last two years. BY JANE ZENTMYER & ED FINKEL

Responding to fears that confidentiality might be breached – or that wary at-risk patients might not come forward for testing – the Illinois Department of Public Health has recommended a two-year trial pro-

gram to track HIV-positive persons by a code reported through health care providers, rather than by name.

IDPH had first proposed that local public health officials start assembling an HIV name registry, which it said would improve prevention and treatment. Illinois already maintains a name registry of persons with AIDS – with more than 20,000 recorded cases since 1981 – but not of HIV-positive individuals.

During hearings held last spring on the issue, AIDS activists testified against expanding the name registry to HIV, stating that discrimination fears would discourage patients from seeking testing, and could actually increase health risks for them and their sexual or needle-

sharing partners.

ISMS President Richard Geline, MD, testified in support of name reporting. He communicated ISMS' policy that a name registry would be the wisest course to assure patients receive proper treatment and counseling. The Society did not reach that position until confidentiality had been properly addressed, he said.

After several months of hearings and discussions, a working group of advocacy, public health, physician, legal and other groups voted to recommend reporting by numbers.

"The working group acknowledged that public health officials routinely handle confidential records without
(Continued on page 10)

ELECTION

League makes first-ever judicial endorsements

BENCH STRENGTH: Physicians focus on electing, retaining Illinois judges. BY JANE ZENTMYER

Last year's Illinois Supreme Court decision striking down historic 1995 tort reform vividly underscored the importance to the medical community of the state's judiciary composition. This is in part why the Illinois Civil Justice League recently announced its first-ever endorsements of qualified judicial candidates running in the Nov. 3 general election – recommendations aimed at giving focus to physicians.

A Chicago-based coalition of organizations that joined forces to pass tort reform, the ICJL understands that electing the right judges can be tricky for voters, given hundreds of competing candidates and relatively scarce information about them.

To fill this knowledge gap, the league created a system to evaluate and endorse judicial candidates. As an ICJL member, ISMS helped create the process and was one of several groups that voted on the endorsements.

"For years, voters have known very little about judges' qualifications, and that has caused some problems," said Edward Murnane, ICJL's president. "Our intention is to help Illinois voters better understand judicial candidates."

Judicial elections work differently than elections for statewide offices. Sitting judges pursuing re-election seek "retention," which means they must win 60 percent of the vote to serve another term. Temporary appointments are made to fill vacancies created by nonretention, retirement or other reasons. Voters elect full-term replacements in the next election.

The ICJL based its first-ever endorsements on candidates' legal experience, recommendations of league members, its judicial advisory committee, evaluations of other organizations as well as candidates' answers to an ICJL questionnaire,
(Continued on page 3)



Michael Gallagher



John Madden

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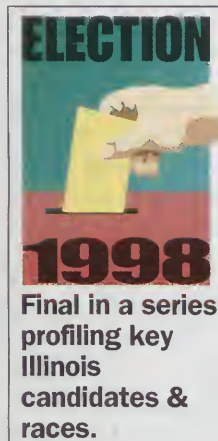
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Comptroller candidates reach out to physicians



BY ED FINKEL

Both candidates for Illinois comptroller said their experience in the medical industry will help them address physicians' needs.

The objective at the top of the list, said attorney Dan Hynes, the Democratic candidate, and State Sen.

Chris Lauzen (R-Geneva) is to expand the gains made by outgoing GOP Comptroller Loleta Didrickson to shorten the time it takes the state to pay Medicaid bills.

Hynes noted that payments have been faster throughout the recent strong economy, but the state should plan to pay bills promptly under rough financial circumstances as well. He recalled that in the early 1990s recession the state legislature exempted Medicaid bills from the Prompt Payment Act, which barred providers from collecting interest. "Naturally, the government paid faster on bills that carried interest, so Medicaid bills were among those that sat the longest," Hynes said.

To avoid those delays in the future,

Hynes has proposed a rainy-day fund for holding money during a healthy economy, which could be withdrawn in leaner times. "It is the comptroller's job to engage in sound financial planning so that Illinois can live up to its financial responsibilities, irrespective of the economic cycle," he said.

Hynes frequently represents physicians in his law practice at Hogan, Marren & McCahill Ltd., a 15-attorney Chicago firm. An associate in health care transactions at the firm, he negotiates reimbursement rates for physicians and helps set up physician hospital organizations and independent practice associations.

"My health care background gives me a strong appreciation for the pressure, both financial and otherwise, that physicians and other health care providers are under because of managed care," he said. "The comptroller is in a unique position to offer HMO reform proposals. I have called for the state to use its \$4 billion in health care purchasing power to demand that HMOs that do business with the state put quality of care before profits." Hynes advocates legislation that would require quick approvals of treatment requests, and an appeals process when coverage is denied.

Both politics and medicine have played a strong role in Hynes' life. His

father, Thomas Hynes, is a former state senator and Cook County assessor. Dan Hynes' fiancée, Christina Kerger, is a second-year medical student at Indiana University. "My respect for physicians has grown" since Kerger began medical school, he said. "I've seen the kind of grueling educational training [medical students] undergo."

Lauzen, a certified public accountant, said he often helps his physician clients collect fees so he knows firsthand how important timely payments are to running medical practices. "I want to continue the progress that's been made by the current comptroller," said Lauzen, who has been a member of the Senate appropriations committee for six years.

Lauzen's legislative record and ISMS' agenda have dovetailed at times and diverged at others. Lauzen earlier this year co-sponsored a bill – backed by the Illinois Nurses Association and opposed by ISMS – that would have allowed advanced practice registered nurses to perform duties such as diagnosing patients without physician supervision. The General Assembly eventually reached a compromise last May that requires APNs to enter collaborative agreements with physicians with similar scopes of practice and prohibits nurses from prescribing Schedule II drugs. "It was good to see the nurses and doctors

come to an agreement," said Lauzen, who voted for the compromise.

Lauzen did not vote on the ISMS-backed managed care patients rights bill that passed the Senate last spring. However, he speaks in support of managed care reform. "I believe doctors ought to decide the best care for patients, rather than an insurance claims adjuster," he said.

Lauzen co-sponsored a bill opposed by ISMS that would have prohibited doctors from billing patients for the balance not paid by workers' compensation insurance.

He voted in favor of the 1995 tort reform law – struck down in 1997 by the state Supreme Court – because he believes physicians should be able to properly care for patients without fear of being sued.

The overall mission of the comptroller's office is to ensure the fiscal responsibility of the state government. Three primary components to reach that goal are: approve state financial transactions to ensure the government's financial accountability, manage the in-flow, out-flow and account transfer of funds, and collect and assess information required to report on the state's fiscal condition.

For a copy of previous Illinois Medicine articles covering key races in campaign 1998, call ISMS at (800) 782-4767, Ext. 1257. ■

Endorsements

(Continued from page 1)

to which about 65 percent of candidates responded, Murnane said.

Because judicial candidates are prohibited from commenting on how they might rule on specific legal issues that could come before them once elected, Murnane said ICJL's questionnaire did not ask candidates their positions on tort reform. Instead, it focused on their opinions on the relationship between the legislative and judiciary branches.

No positions are currently open on the seven-member Illinois Supreme Court. Three spots are open on the state's five appellate courts, and two appellate justices are seeking retention.

ICJL recommended that voters retain sitting justices Calvin Campbell and Allen Hartman for 10-year terms on the 1st District Appellate Court, which encompasses Cook County.

Candidates are vying for two 1st District Appellate Court seats created by the retirements of Dom Rizzi and Edward Egan. For Rizzi's seat, the ICJL endorsed

Democrat Michael Gallagher, a former ISMIE defense attorney, over GOP opponent Sam Amirante. Gallagher was appointed to fill Rizzi's position in 1996; he now seeks a full 10-year term.

Before reaching the appellate court, Gallagher spent six years as a Cook County Circuit Court judge. He was also a partner at the Chicago-based Cassiday, Schade & Gloor, where he concentrated in appellate and trial practice related to medical malpractice and general negligence.

The ICJL recommended that the second spot open on the 1st District Appellate Court go to Republican John Madden, not his Democratic opponent, Margaret Stanton McBride. Madden was appointed an associate judge in 1984 and elected a circuit court judge, the position he now holds, in 1992. Prior to that, Madden spent 14 years as an attorney in the Cook County Public Defender's office.

The third open seat is in the 4th Appellate District in central Illinois. This race pits two candidates familiar to physicians. Democrat Sue Myerscough is chief justice of the 7th circuit court in Sangamon County and Republican Thomas Appleton is a judge in that court. The ICJL gave the nod to Appleton.

Appellate courts are pivotal to the state's judicial system. They are usually a stepping stone to the Supreme Court. And, although judicial vacancies are filled by the Supreme Court, appellate court justices often are called on to make recommendations for those appointments. Also, appellate justices' decisions are binding on every trial judge in the appellate court district and, in some cases, on trial judges in other appellate court districts.

See page 5 for a complete list of ICJL's recommendations. ■

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EDITORIAL

Next year is here

Like die-hard Cubs fans, tort reform supporters never give up. On Nov. 3, almost one year after the Illinois Supreme Court sent tort reform to the showers, physicians can use the ballot box to help draft a lineup of decision makers likely to revisit this issue in the future.

Unfortunately, media coverage of judicial races is often limited, leaving voters with little knowledge of the background and qualifications of people seeking to head the courts. The Illinois Civil Justice League has taken that problem to heart. The coalition dedicated to Illinois tort reform has for the first time endorsed candidates in contested judicial elections and also made recommendations for, or against, judges seeking retention.

ICJL endorsements are based on several criteria, including responses to a questionnaire it developed, and evaluations and ratings of various organizations. The group reviewed the campaign contribution reports of all candidates considered. A list of ICJL endorsements and recommendations is on the following page, which can be easily clipped out and carried into the voting booth for easy reference.

Physicians must also use their ballot muscle to support candidates in federal and state races who are in organized medicine's corner, particularly during this era of unprecedented political attention to health care reform.

ISMS members need look no farther than their own backyard for candidates to

support. Two fellow members are ready and willing to make health care reform a top priority in Congress. Chicago urologist Herb Sohn, MD, the Republican candidate running in the 9th Congressional District, faces a tough battle against Ill. Rep. Janice Schakowsky (D-Evanston). Belleville orthopedic surgeon William Price, MD, needs physicians' help to unseat incumbent Democrat Jerry Costello in the 12th Congressional District.

At the state level, ISMS Alliance member Rep. Gwenn Klingler (R-Springfield) has also earned physicians' vote through her strong support of managed care patient-rights legislation. She is married to Springfield dermatologist W. Gerald Klingler, MD.

Articles in the last several issues of Illinois Medicine detailed candidates' health care positions in key state and federal races. Another voting resource is the Illinois State Medical Society Political Action Committee, which carefully screens candidates in state and federal races to identify those sensitive to physician concerns.

Call ISMS at (800) 782-4767 to receive issues of Illinois Medicine's election coverage, or for help identifying the legislative district in which you reside.

Cubs fans may be waiting for next year, but the medical community does not have to wait that long. By voting on Nov. 3, you can immediately hit a grand slam for health care.

Next year is here. ■

PRESIDENT'S LETTER

Help available to ease mounting antitrust anguish

Richard A. Geline, MD



*Physicians ...
may find
themselves
bumping up
against a broad
set of laws
under the term
"antitrust."*

As our health care delivery system evolves, the physicians' rule book is becoming more complex. These changes are evident in our practice arrangements; physicians practicing in groups or as employees now vastly outnumber those in solo private practice – a segment that now accounts for only about one quarter of working physicians.

Corresponding to this shift is the formation of new entities and organizations to which physicians belong. Independent Practice Associations, staff-model Health Maintenance Organizations, Physician Hospital Organizations, multispecialty groups, single-specialty groups and even physician unions are just some of the new creations. (My personal favorite is the OWA, or "other weird arrangements.")

As the market consolidates from many small players to fewer, larger ones, physicians forming and joining these alternative groups may find themselves bumping up against a broad set of laws under the term "antitrust."

Antitrust laws are meant to preserve competition by regulating cooperative activity among sellers or services. Health care delivery networks organized by physicians and/or other providers constitute such cooperative activity. Cooperative arrangements among competitors or among other participants that unreasonably restrain competition in a market are illegal.

These issues were first addressed by the United States Department of Justice and the Federal Trade Commission in a report titled, "Statements of Antitrust Enforcement Policy for the Health Care Area," issued in 1993 and updated in 1994 and 1996. A potential antitrust offense can be deemed "illegal per se," which means it is such a threat to competition that it is illegal regardless of the circumstances, or subject to the "rule of reason," under which it is evaluated to determine its material adverse effect on competition.

Some examples of antitrust offenses include price fixing, group boycott or concerted refusal to deal, division of market, exclusive dealing and illegal merger. The DOJ recently filed suit against a physicians' union in Delaware, accusing it of organizing an illegal boycott by orthopedic surgeons against a Blues plan. (The union denies the charge.) The FTC is reportedly set to take a closer look at multi- and single-specialty groups that are growing large enough to threaten competition in their markets.

Becoming expert in every detail and nuance of the DOJ/FTC report is something most physicians are happy to leave to others. Nonetheless, a working knowledge of the topic is essential in today's environment. The AMA reviewed the matter in depth in 1996 and provided a report to the House of Delegates that gives physicians a good summary of the law and how it may be applied.

Organized medicine has, in fact, followed the process closely and can act as an important resource for physicians. The AMA is fighting in Congress for the Quality Health Care Coalition Act, which would level the playing field for the solo practitioner by carving out an antitrust exemption that allows individual physicians to collectively bargain with health plans.

Both ISMS and the AMA provided extensive support to the doctors who organized the Rockford Physicians' Council, helping them avert antitrust land mines and successfully use federal labor laws to win a greater voice in patient care issues within the Rockford Health System.

Staff experts in the ISMS Division of Health Policy Research can provide an overview of the laws and their implications, and refer physicians to consultants who can give specific advice on individual situations. This is another example of your ISMS membership dues at work. ■

Illinois Civil Justice League endorsements

As part of its campaign to reform the state's judicial system, the Illinois Civil Justice League has endorsed judicial candidates in the Nov. 3 election.

The following list, which can be easily carried into the voting booth for reference, details the league's endorsed candidates.

Circuit court races

Recommended for retention outside Cook County

2nd circuit

COUNTIES: Crawford, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jefferson, Lawrence, Richland, Wabash, Wayne, White

Judges: Larry O. Baker, David M. Correll, Terry Gamber, Robert M. Hopkins, Robert J. Keenan Jr.

4th circuit

COUNTIES: Christian, Clay, Clinton, Effingham, Fayette, Jasper, Marion, Montgomery, Shelby

Judge: Michael P. Kiley

7th circuit

COUNTIES: Greene, Jersey, Macoupin, Morgan, Sangamon, Scott

Judges: Thomas R. Appleton, Leo J. Zappa Jr.

8th circuit

COUNTIES: Adams, Brown, Calhoun, Cass, Mason, Menard, Pike, Schuyler

Judge: Carol Pope

9th circuit

COUNTIES: Fulton, Hancock, Henderson, Knox, McDonough, Warren

Judges: William D. Henderson, David Hultgren, Stephen C. Mathers

11th circuit

COUNTIES: Ford, Livingston, Logan, McLean, Woodford

Judge: Ronald C. Dozier

13th circuit

COUNTIES: Bureau, Grundy, LaSalle

Judge: James A. Lanuti

16th circuit

COUNTIES: DeKalb, Kane, Kendall

Judge: Pamela K. Jensen

18th circuit

COUNTY: DuPage

Judges: Robert E. Byrne, John W. Darrah, Robert K. Kilander, Ronald B. Mehling, Bonnie M. Wheaton

19th circuit

COUNTIES: Lake, McHenry

Judge: Jack Hoogasian

20th circuit

COUNTIES: Monroe, Perry, Randolph, St. Clair, Washington

Judge: Lloyd A. Karmeier

Recommended for retention Cook County

Richard B. Berland
Richard J. Billik Jr.
Bernetta D. Bush
Thomas F. Carmody
Joan M. Corboy
David Delgado
Deborah Mary Dooling
Jennifer Duncan-Brice
Arthur L. Dunne
Timothy C. Evans
Sheldon Gardner
Allen S. Goldberg
Susan Ruscitti Grussel
Shelvin Louise Marie Hall
Sophia H. Hall
Thomas A. Hett
Cheryl D. Ingram
Aaron Jaffe
Raymond L. Jagielski
Sidney A. Jones III
Daniel F. Jordan
Carol A. Kelly
James W. Kennedy

Dorothy Kirie Kinnaird
Bertina F. Lampkin
Daniel M. Locallo
John K. Madden
William D. Maddux
William Maki
Patrick E. McGann
John J. Moran
Michael J. Murphy
Sheila M. Murphy
Julia M. Nowicki
Donald J. O'Brien Jr.
William M. Phelan
Robert J. Quinn
Thomas P. Quinn
Maureen Durkin Roy
Leida Gonzalez Santiago
Stephen A. Schiller
Daniel J. Sullivan
John A. Ward
Dan Weber
Alexander P. White
Susan F. Zwick

Not recommended for retention Cook County

Llweilln "Lynn"
Greene-Thapedi
Dorothy Jones
Jeffrey Lawrence
Susan J. McDunn

Janice R. McGaughey
Paddy H. McNamara
Denise M. O'Malley
William D. O'Neal
Edna M. Turkington

Contested circuit court races outside Cook County

5th circuit

COUNTIES: Clark, Coles, Cumberland, Edgar, Vermilion

Garman vacancy:
✓David J. Ryan (D)

Pearman vacancy:
✓James R. Glenn (R)

17th circuit

COUNTY: Winnebago

Agnew vacancy:
✓Janet R. Holmgren (R)

19th circuit

COUNTIES: Lake, McHenry

Block vacancy:
✓Terrence J. Brady (D)

Contested circuit court races Cook County

DiVito vacancy:

✓Thomas L. Hogan (D)

Komosa vacancy:

✓James McCarthy (D)

Lassers vacancy:

✓Edward Green (R)

O'Brien vacancy:

✓Paul Philip Biebel (D)

Strayhorn vacancy:

✓Daniel J. Kelley (R)

White vacancy:

✓John E. McNeal (R)

13th subcircuit

Bonaguro vacancy

✓Thomas P. Fecarotta Jr. (R)

Appellate court races

Contested

1st district: Cook County

Egan vacancy:

✓John K. Madden (R)

Rizzi vacancy:

✓Michael J. Gallagher (D)

4th district: Central Illinois

Green vacancy:

✓Thomas R. Appleton (R)

Recommended for retention

1st district: Cook County

Calvin C. Campbell, Allen Hartman



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ISMIE Update

Lights, camera, liability

Taking control of camcorders in the delivery room.

BY JAY FERRARI

Today's preferred image-preserving technology, the video camcorder, is as ubiquitous a piece of equipment as the Instamatic was back in the 1970s. Their affordability and ease-of-operation have made them a common accessory for expectant fathers, who take them "on location" at the birth of a son or daughter.

The popularity of filming childbirth has recently expanded the debate on allowing families to videotape obstetric procedures. What was once a "new toy" now too often becomes a legal tool. If things go right, the physician's stellar performance is on the record. If things go wrong, however, a video has the potential to play a starring role in a malpractice lawsuit.

Which is why more and more hospitals are making it policy not to allow camcorders into delivery rooms. Following their lead, insurance companies are issuing strong recommendations against the practice. It's become too much of a legal hot potato, all involved say.

Some in the liability industry say that knowing individual recommendations and policies of

their hospital or insurance company can often give physicians an easy way to ban cameras altogether — "I'm sorry, it's out of my hands. I'm not allowed to authorize camcorders in the delivery room."

To further cool physician concerns, many hospitals are clarifying policies specific to prohibiting video cameras in the delivery room.

A recommendation by The American College of Obstetricians and Gynecologists' Committee on Professional Liability discourages any recording of medical or surgical procedures for patient memorabilia. The scenario, the committee asserts, "is not without" liability.

Physicians, therefore, should have a complete understanding of their own hospital's policy before they permit one's presence.

But even when hospitals allow cameras, many legal experts are adamant that cameras should be prohibited from the delivery room outright.

"It is simply too intrusive," explained attorney Kevin Glenn of Worker & Power in Chicago.



Video guidelines for physicians

- Have a thorough understanding of your hospital's video-camera permission policy.
- Get written permission to be photographed from the mother — and include it in her medical chart.
- Explain that taping is at your discretion.
- Require the camera's audio be turned off.
- Have the photographer stand by the patient's head.
- Meet with the patient after delivery to explain any "confusing" scenes complications might have created on the video.

"Yes, there is a desire to record the event, but independent of that, there is medical work that must be completed."

He fears that occasionally a camera-carrying father may have an ulterior motive. "A birth is a

wonderful moment," he said, but he questioned if it always is for "the historic record." The often-lucrative nature of malpractice suits is too well known never to be a factor in bringing a camera into the delivery room, he said.

According to Glenn, fathers fixated on their cameras are also missing a more important obligation. The mother is having an emotional and physical experience, he said. The father should be concentrating on coaching and comforting her. Physicians are correct, Glenn maintains, when they use this line of reasoning to explain why a camera is not merely distracting, but dangerous.

"The focus should be on giving birth, not on making a home movie," Glenn concluded.

David Cromer, MD, an Evanston-based Ob/Gyn, as well as a member of the ISMIE Risk Management Committee, underscored Glenn's legal advice with medical common sense.

Fathers are there to be supportive of the mother, he said, not to be running around taking pictures and causing distractions. As an example, Dr. Cromer related one incident in which he walked into the deliv-

ery room and there were two cameras set up on tripods pointed at the mother.

"That is simply not appropriate. My impression is that most women don't want the actual moment of birth on tape. That is simply not discrete," Dr. Cromer said.

Many medical and legal experts agree that physicians who understand the implications of a video camera in the delivery room will diplomatically insist that, at the very least, it is operated solely at their — the physician's — discretion. Dr. Cromer is willing to permit a video camera in the delivery room provided its use is controlled by the physician. The doctor must always be the real director, not the person behind the camcorder.

"Individual physicians need to have an understanding with each couple about videotaping a birth," he explained. "But everyone must understand that whether it is on or off is the physicians' prerogative."

And as for location, Dr. Cromer added that keeping the camera behind the mother's head, where the father traditionally stands, is its only appropriate position — provided the camera is permitted in the delivery room at all.

This will minimize a host of potential problems both during and after any birth. However, whatever their position on cameras in the delivery room, it is incumbent on physicians to call the shots. Otherwise, what was to be a keepsake might become key evidence. ■

MALPRACTICE ROUNDUP

Ruling on emotional distress

The Supreme Court of Colorado has ruled that a patient may recover damages for emotional distress caused by a physician's failure to promptly diagnose her breast cancer.

Court records regarding *Boryla v. Pash* indicate that in Feb. 1990, the plaintiff discovered a lump in her right breast during a self-exam. Her family physician referred her to the defendant, who performed a biopsy but did not request a mammogram. Results from the biopsy were negative.

Two months later, the plaintiff returned to the defendant, complaining the lump had not gone away.

The defendant performed a needle aspiration, but did not draw blood. He asked the plaintiff to return in two weeks if the problem persisted. After three weeks, she returned; a mammogram noted an irregular mass that was "highly suspicious for a malignancy." A biopsy determined the growth to be cancerous and invasive. A radical mastectomy and the surgical removal of the plaintiff's lymph nodes were performed. The surgery was successful, and there has been no recurrence of cancer.

The plaintiff sued for damages caused by the 92-day delay in diagnosing her cancer. She claimed the delay resulted in an increased number of cancer cells in her body and caused the tumor to grow. She sought damages for mental and physical pain and suffering,

emotional distress, loss of enjoyment of life, loss of time, and other physical and psychological injuries.

A jury awarded the plaintiff \$220,000 in noneconomic damages only. Despite the defendant's arguments to the contrary, an appellate court ruled that the plaintiff need only show her fear of cancer recurrence was reasonable and proximately caused by the defendant's negligence. However, it also said she had failed to meet that standard, which vacated the jury's award.

The supreme court decision reversed the appellate ruling, finding that by introducing evidence proving her condition had physically worsened as a result of the delayed diagnosis, the plaintiff established attendant physical injury, permitting the jury to consider her claims for emotional distress.

Tumultuous times in the transplant world

New policies seek to create more donors, better distribution – and happier endings.

BY JEFF BLACK

There are too few happy endings in the world of organ transplants, medical experts lament. A woefully inadequate pool of organs available for transplantation, inequities in distribution and constantly shifting policies too often prove insurmountable barriers. Yet happy endings can be found. Just ask heart surgeon Christine Lawless, MD, of Loyola University Medical Center, who is glad to share the experience of one of her patients.

Jack, a Chicago resident, suffered a heart attack in July 1991. He was 38 years old. Blocked arteries made it nearly impossible to breathe. Suffering severe heart failure, Jack was on multiple medications that, among other things, made fathering a child impossible. Jack's prognosis was bleak. Then, in June 1992, Jack received a new heart. His recovery was remarkable and complete. Now back at work, a healthy Jack is kept even busier helping his wife raise triplets, born in the summer of 1997.

But Dr. Lawless also cited two patients whose lives she fears will not have the same sorts of endings: Cheryl, 38, longing to be home with her newborn; and Willie, just 13, who wants nothing more than to return to school. Their stories may well be cut short for lack of donated hearts, Dr. Lawless said.

They are not alone. Nationwide as of July 1, over 60,000 Americans were waiting to receive donated organs. More than 300 Illinoisans died while waiting

for an organ to become available for transplant in the same year Jack became a father. The Illinois number is revealing of this national shortage, particularly since the state's donation program, run by Secretary of State George Ryan's office, is widely considered the best in the country. Having more than 4 million names in the state's donor registry makes it the envy of the nation, as does its well-funded outreach program. But even these are not enough.

"Something must be done," Dr. Lawless said of the worsening situation.

Efforts to rectify the situation are increasing. ISMS is on record as vigorously supporting programs to meet critical and ever-growing transplantation needs. Although everyone has the same goal – saving lives – there are opposing views on how best to proceed. Behind the scenes these are tumultuous times in the transplant world.

The most recent attempt to increase the organ-donation pool is a new U.S. Health Care Financing Administration policy that took effect Aug. 21. The new rule requires hospitals to notify their region's organ procurement organization – OPO – of any individual whose death is imminent or who has died in the hospital, so the OPO can determine medical suitability of the deceased for organ and/or cornea donation.

Further, the new policy stipulates that only OPO staff, or a person designated and trained by the OPO, can approach potential donor families to request the donation. Noncompliance with the HCFA rule could result in a hospital losing its Medicare funding.

The OPO for the northern three-quarters of Illinois, as well as for northwest Indiana, is the Regional Organ Bank of Illinois. ROBI facilitates donation and transplant policy, no matter what allocation plan is in place, according to David Bosch, a spokesperson for the organization.

"Many states, including Illinois, had organ donation policies prior to the HCFA announcement," stated Bosch. "The previous policy answered the who, what and when of soliciting organs. Some physicians didn't always follow the criteria. The new HCFA rule seeks to fix that."

Dr. Lawless, too, noted some physicians' reluctance to ask for organs. "You have to understand," she said, "they are personally invested in these situations. It's difficult to move immediately from a life-saving mode to one of asking for transplant organs."

HCFA's rules are meant to relieve physicians of the burden of talking to family members about donation by assigning that task to ROBI representatives, who don't have a relationship with the patient. The physician can still participate in the discussion, but only after he or she has received "extensive and intensive" ROBI training, Bosch said.

The blanket nature of the rule could exasperate some physicians. It requires them to call ROBI upon the deaths of even obviously unsuitable candidates for organ donation, including AIDS patients or 95-year-olds. A ROBI reference sheet mailed to Illinois hospi-

Organ Transplant Waiting List

	Illinois			U. S.
	JULY '98	JULY '97	JULY '96	JULY '98
Kidney	2,021	1,874	1,729	40,029
Kidney-Pancreas	140	132	117	1,738
Heart	147	156	159	4,146
Liver	1,019	783	611	10,811
Lung	110	74	42	2,929
Heart-Lung	0	3	6	240
Pancreas	49	34	31	484
Intestine	7	3	2	88
TOTAL	3,493	3,059	2,697	60,465

Source: Regional Organ Bank of Illinois

(Continued on page 8)

Sudden hospital stays don't preclude voting

An unforeseen hospital stay requires extra paperwork – plus the help of an accommodating relative and attentive physician – to ensure that a patient hospitalized less than five days before an election can cast a ballot.

The regular absentee ballot system does not work for last-minute admittees because the application must be submitted at least five days before an election. However, anyone hospitalized less than five days before an election is entitled to arrange for the direct delivery of an absentee ballot. The voter will need:

- A special absentee ballot request, form SBE-A12.
- A confirmation certificate signed by the attending physician.
- An affidavit signed by a relative or precinct voter representing the hospitalized voter that confirms the physician's authorization.

Upon receipt of the application, the certificate and the affidavit, the election authority verifies that the applicant is qualified to vote. That final criteria met, a representative from the election authority delivers a ballot directly to the hospitalized voter. Marked in secret, the ballot is then given to the voter's relative or another precinct voter for delivery to the election authority, who in turn takes the ballot to the polls.

For additional information, or to arrange for the delivery of an absentee ballot to a hospital for the Nov. 3 election, contact the Illinois State Board of Elections at either its Chicago office, (312) 814-6440, or its Springfield office, (217) 782-4141.

Transplant

(Continued from page 7)

tals indicated that "these calls will be very brief" – but still mandatory.

Bosch said that so far things have run smoothly. He noted that the most difficult aspect of the policy change was the relatively little time they were given – 60 days – to get everyone up to speed. "This changes what hospitals do, so they have to outline and implement new internal policies. That's not easy," he acknowledged.

Any disagreements arising over details of organ-donor pool expansion will pale in comparison to the dust-up created by changes requested by the U.S. Department of Health and Human Services in the way available organs are distributed for transplant. Now enjoying a respite of relative calm, earlier this year the gloves were off as high-profile combatants sparred ferociously.

At issue was a federal directive aimed at reshaping the nation's organ-transplant policies. In April, HHS ordered the national network responsible for coordinating organ distribution – the United Network for Organ Sharing, composed of the country's 275 transplant centers, other medical organizations and the general public – to come up with new distribution guidelines based on HHS goals. Drawing the heaviest criticism, as well as publicity, was what was roundly regarded as HHS' desire to shift from a locally based organ allocation system to a single national list based on medical urgency. Critics of the policy, including UNOS itself, warned that such a move could leave some states without organs for their own sick citizens; instead, they said, these organs will be shipped to other parts of the country.

UNOS, of which ROBI is a member, quickly dubbed the HHS proposal "sickest-first" and thus unworkable. Even though UNOS is responsible for crafting the final rules, it said the changes will undermine the current transplant-distribution system. Among the detriments of a national waiting list predicted by UNOS are longer waits for organs, higher rates of transplant failure, decreased access to transplants for the poor, and increased closure of smaller, regional transplant surgical centers. UNOS warned that "the government's proposed transplant regulations could result in potentially tragic human consequences."

HHS Secretary Donna Shalala shot back. She said the new policy would end the vast difference in time spent on organ-donation waiting lists that now exists between states. She also challenged the veracity of UNOS' statements, and cited as "untrue" any desire on the administration's part for a single national waiting list for transplant patients. It was regrettable, Shalala wrote, that "UNOS has decided to craft a set of fictional facts and choices in order to make plausible the dire scenarios necessary for their lobbying campaign to succeed."

Joining the fracas, several states have now passed laws ordering that donated organs remain within their borders. Statehouse rhetoric has been heated. While signing his state's law, Okla. Gov. Frank Keating said, "The federal government is trying to [steal] organs from small and middle-size states." Louisiana has filed suit against Shalala, seeking an injunction against policy changes they fear will take organs from their state.

As initially directed, UNOS had, as of Oct. 1, 60 days in which to devise a plan regarding liver distribution that would meet HHS standards, and until Oct. 1, 1999 for a plan covering all other organs. However, delayed congressional action on appropriations bills has impacted the timetable. An impending federal district court ruling on Louisiana's request for an injunction could throw it into complete disarray. Observers agree that changes, if any, will come later rather than sooner.

"A scenario like this, played out so publicly through the media, gives people an impression that something wrong is going on," ROBI's somewhat dismayed Bosch said. "What this fight really points out, the real bottom line, is that we don't have enough organs for transplantation."

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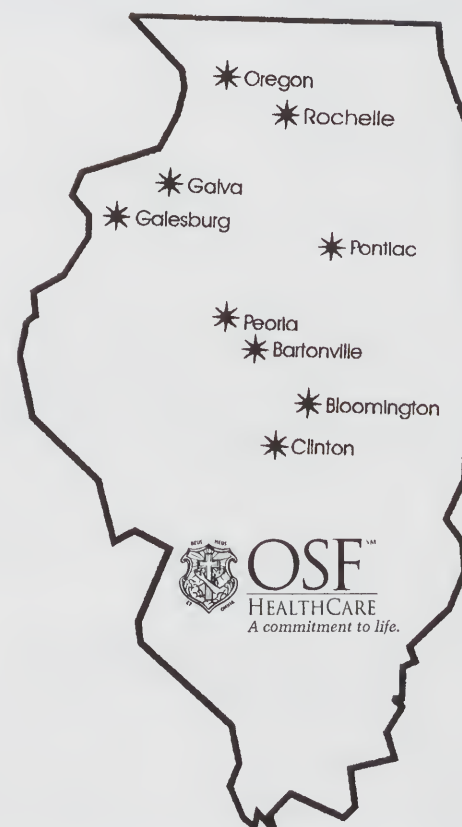
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HIV reporting

(Continued from page 1)

disclosure," said IDPH Director John Lumpkin, MD. "However, there was concern that the specter of unlawful disclosure would create a barrier to individuals seeking testing and treatment."

"They've come up with something new to try to accommodate everyone's concerns," said Dr. Geline. He said the Society continues to support its policy that calls for name reporting.

If approved by the legislature's Joint Committee on Administrative Rules at its October meeting, the IDPH plan

would take effect next July 1 and run two years, when performance would be evaluated and continuation weighed.

Under the IDPH plan, providers, upon diagnosis, would assign an identifier number signaling demographic, ethnic, gender and other information. Chet Kelly, chief of the department's HIV/AIDS section, said if the legislative rules committee gives the go-ahead, the department most likely would develop a simple report form with boxes to fill in. The department plans to release details by the spring, he said.

"We don't want to be overly burdensome to the physician or other

providers," he said. "We would hope to set it up so information they would normally be collecting would be placed in the right place, and they would have a code number generated."

Among criteria to be examined in a six-month evaluation period beginning Jan. 1, 2001 would be the completeness of data constituting patient code numbers, the ease with which providers can link code numbers back to patients for follow-up treatment and the quality of data provided in case reports. One concern is that without names, the same patient could be reported more than once.

Kelly said when the department starts

educating physicians about the system, officials will stress the importance of partner counseling and referral services, and will note that the health department can help in those areas — in other words, providers are not on their own.

"We think this system we are proposing will achieve our goal of being better able to track the epidemic, and will allow us to assist with the appropriate follow-up services to those persons who test positive," Kelly said.

Texas and Maryland are the only two states to have tried similar systems, Kelly said. Maryland plans to continue evaluating its program, while Texas has decided the system didn't work and has switched to name reporting. California and Massachusetts also are poised to begin numerical reporting. ■

E&M rewrite

(Continued from page 1)

'checklists' to indicate that an item has been performed," the guidelines stated.

Despite their opposition to this checklist approach, delegates urged the AMA to keep working with HCFA.

Randolph Smoak, MD, chairman of the AMA Board of Trustees, said the AMA "strongly regrets" HCFA's insistence on quantitative formulas. However, he added, the AMA did persuade HCFA to reduce the emphasis on these formulas, and to conduct pilot tests of reworked guidelines before implementation.

Dr. Smoak added, "The concerns of the medical profession and our patients will be best represented if it asks the CPT Editorial Panel to resume providing technical advice to HCFA."

HCFA plans to use a "new framework" as a starting point for developing guidelines, Dr. Berenson said.

Developed earlier this year in conjunction with the medical profession, it is the version delegates roundly criticized in June. It is also the version presented last April to more than 300 physicians and others who attended an AMA-sponsored fly-in meeting in Chicago.

The AMA convened the fly-in after the release of the original 1997 documentation guidelines resulted in an angry uproar.

HCFA announced at the fly-in that it would delay implementation of the 1997 E&M guidelines until they could be rewritten. In the interim, physicians can use the 1995 or 1997 guidelines to document their work.

HCFA has not set a target date to finish its rewrite or to implement the new guidelines, Dr. Berenson said.

By resuming discussions with HCFA, the AMA said it will be able to work on minimizing the overall documentation burden.

As Dr. Smoak put it, "Renewed work with HCFA is needed so physicians will not face documentation guidelines that do not reflect broad, practicing physician input and experience."

Physicians who have been denied payment due to inappropriate coding are encouraged to call the ISMS Health Care Finance division, which provides assistance on third party payment issues. ISMS will use examples it receives — including correspondence and explanation of benefits — to demonstrate to HCFA the impact of its policies. For further information, call ISMS at (800) 782-4767. ■



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Illinois Medicine

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"60 Minutes" reaction

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Reformists cry out for managed care change

TOWN MEETING

MESSAGE: Physicians must take part in the solution. BY KAREN TITUS

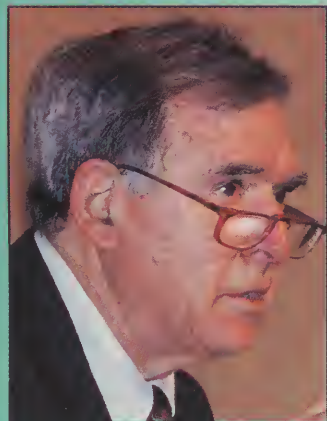
When Linda Peeno, MD, a former medical director for a major managed care organization in Louisville, Ky., started working on the administrative side of medicine, she believed she could maintain a solid footing in sound medical practices.

However, by the time she quit the managed care business nine years ago, Dr. Peeno said she was "stripped of any sense I had that I was a physician. Physicians [in administrative roles] often had no connection to the consequences of their decisions," she recalled. "Many times we were making decisions about patients we never saw, who often were in another state. I was working in an environment where illness was seen as a liability."

Dr. Peeno outlined her case against managed care Oct. 10 at a health care reform summit and town meeting at Chicago's Mercy Hospital. The event was sponsored by the Illinois Ad Hoc Committee to Defend Health Care, a group composed of about 1,200 physicians and nurses who joined together last year to oppose the takeover of

"Managed care's grip on medicine continues to tighten, often without widespread awareness."

— Linda Peeno, MD



Photos by Kevin Mooney

"Managed care totally neglects the community function, education function and clinical research function [of medicine], without which you do not have a health care system."

— Arnold Relman, MD

health care facilities by for-profit companies, according to its co-chairman, James Webster Jr., MD, professor of medicine at Northwestern University Medical School, Chicago.

The meeting provided a

forum for health care providers to air their outrage against managed care.

Because of managed care, said Beth Blackson, RN, "Patients in today's health care institutions are being deprived

of expert nursing care," including monitoring of medications, bedside assessments, patient education and error checking.

"The effects on clinical social work have been profound," added David Rosenfeld, president of the Illinois Society for Clinical Social Work. "Patients' interests, client advocacy and privacy between patients and therapists have all been compromised by managed care," he said. And even though the short-term crisis management advocated by managed care can work well in appropriate situations, Rosenfeld cautioned that "what's problematic is that managed care organizations try to fit all patients into that model."

The managed care industry likes to dismiss as mere anecdotes the horror stories about managed care abuses, said Dr. Peeno. But in reality, plenty of evidence exists, she explained. "The materials are out there — but much of it is sealed in court records as part of settlement agreements between managed care companies and plaintiffs." Without that information, she said, it is incumbent on physicians and other health care professionals to speak against managed care's impact on patients and the medical profession.

(Continued on page 10)

Federal court upholds Texas patients' right- to-sue law

REACTION: What's good for Texas should be good for the nation

BY JANE ZENTMYER

In a victory for the patient rights movement, a federal district court recently upheld a Texas law that allows patients to sue their managed care plans for negligent quality-of-care decisions.

The 1997 state law was the first of its kind in the country, and it kicked off a nationwide crusade encouraging Congress to nix the exemption from state medical malpractice laws employer health plans enjoy under the Employee Retirement Income and Security Act of 1974.

The Texas Medical Association is pleased the appeals court affirmed the state's right to regulate quality-of-care questions, said Robert Sloane, MD, chairman of TMA's Council on Legislation, after the September ruling. But federal action is needed so that the impact is nationwide, he said, emphasizing the importance that Congress clarify that doctors — not insurance companies — make medical decisions and that insurers are held accountable when they impose their judgment or interfere with medical decisions.

ISMS President Richard Geline, MD, agreed: "All health insurance plans should have to meet the same quality-of-care standards that consumer protec-

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Potential for physician liability grows with duties of PAs, nurses

PREVENTION: Risk management tactics can avert trouble. BY JANE ZENTMYER

Every health care worker in a physician's office is part of a team in the delivery of patient care. If one team member drops the ball, others may suffer the legal consequences. That liability risk for physicians is likely to grow in the near future, along with the growth in numbers of nurses and physician assistants.

Relationships between physicians and nurses and physician assistants are currently adapting to new circumstances, due to recent legislative actions. Illinois

recently became the last state in the country to legally recognize advanced practice nurses. And in 1997 the Legislature renewed the Physician Assistant Practice Act, permitting added responsibilities, such as limited prescriptive authority.

These changes may encourage physicians to reevaluate their working relationships with employed midlevel practitioners, or to hire a PA or APN. But, keep in mind: "If a PA or nurse performs an act that is found to

be negligent, then as their employers, physicians are liable," said David Drake, an attorney and partner at Drake,

(Continued on page 2)



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Legislators listen to women's health matters

Former ISMS President Sandra Olson, MD, (right) offers input on women's health issues to State Rep. Carolyn Krause (R-Mt. Prospect) during a recent community dialogue session sponsored by the Governor's Commission on the Status of Women in Illinois. The event at the Northwest Community Hospital Wellness Center in Arlington Heights was one of about 15 such forums held statewide to solicit community leaders' input for the commission's final report to Gov. Edgar.



Andrew Corrigan-Halpern

Medical faculty urged to snuff tobacco investments

Building on momentum achieved last year, physicians – especially those who are medical school faculty – are again being asked to support a campaign urging the Teachers Insurance and Annuity Association/College Retirement Equities Fund to divest tobacco-related investments in its portfolio.

At its annual meeting, to be held Nov. 10 in New York City, CREF members will vote on a divestment proposal co-sponsored by former U.S. Surgeon General C. Everett Koop, MD, and Eugene Feingold, MD, "to get educators' retirement savings out of lethal tobacco." The proposal calls for CREF to "begin an orderly divestment of all tobacco products."

CREF members can vote for the proposal via a mail-in ballot they should have received by Oct. 15.

In rallying support for the divestment vote, Dr. Feingold told physicians that CREF has invested nearly \$2 billion of educators' retirement savings in tobacco products which, when used as directed, produce "disease and premature death for a third of [its] long-time users, including our own students."

The ISMS House of Delegates is on record as adopting a resolution supporting CREF's tobacco divestment. CREF members who have not received a mail-in ballot should call (800) 842-2733. For more information about the campaign, call Educators for Tobacco Free Investments at (734) 662-8788.

Physician/public input sought for HHS project

Chicago-area physicians and the general public will have an opportunity to shape the nation's health-care agenda for the new century at a regional goal-setting meeting to be held in Chicago.

Hosted by the U.S. Department of Health and Human Services, the meeting, said HHS officials, will be part of the crucial "public comment phase" of its Healthy People 2010 project. Currently, the project proposes more than 500 national objectives for improving the health of Americans by the year 2010. Final project objectives – reflect-

ing public input from the Chicago gathering, as well as from four other regional meetings and a national consortium – will be released in January 2000.

"At a time when consumers are expressing an unprecedented interest in decisions related to their health, our call for citizen involvement is especially fitting," said HHS Secretary Donna Shalala. "To make Healthy People 2010 a success, we need to hear the ideas and the concerns of the American people."

Healthy People 2010 has four main goals: promote healthy behaviors, pro-

mote healthy and safe communities, improve systems for personal and public health, and prevent and reduce diseases and disorders.

The Chicago-area public discussion will be held Nov. 5 and 6 at the Hyatt Regency Chicago Hotel. For registration materials, call (800) 367-4725.

The Healthy People 2010 draft supports goals proposed by the Clinton Administration's initiative to eliminate racial and ethnic disparities in health.

The document may be ordered by calling HHS Office of Defense Prevention and Health Promotion fax-back system at (301) 468-3028.

Physician liability

(Continued from page 1)

Narup & Mead in Springfield.

Should physicians still be concerned even if the PA or nurse is not an employee? Absolutely, Drake said. "The supervising physician should still have risk management strategies in place regardless of whether the [midlevel practitioner] is an employee. The plaintiff's attorney will find a legal theory

that holds physicians responsible."

Physicians are busy people, Drake said, and when midlevel practitioners pick up additional work, it opens the door to liability exposure. "The PA or nurse may do something beyond what they're capable of doing," Drake said. "They have to know their limitations and what kinds of rules or guidelines are in effect so they know when to go to their supervising physician with a problem."

Written guidelines can clearly define

health professionals' roles and responsibilities in a physician's practice. "It is very difficult to tell someone what to do with every patient who walks in the door," Drake acknowledged. But guidelines can specify, for example, which types of illnesses or which types of patients, such as infants under three months of age, require a physician's input.

In fact, the recently enacted APNs' law requires the nurse and physician to

sign a jointly developed written collaborative agreement. More details on the agreements will become available when the Illinois Department of Professional Regulation drafts rules for the law's implementation.

No matter how busy they are, physicians should also be easily accessible to the APNs and PAs they work with. "Always be certain they know it's not an inconvenience to come get you," said Lonnie Laughlin, MD, a family physician at the Litchfield Family Practice Center.

A physician is always available to the practice's midlevel practitioners, Laughlin said.

Good documentation by all parties also will make a difference, said Oran Whiting, an attorney with Fedota, Childers & Rocca in Chicago. Physicians should discuss with a midlevel practitioner what details to place in the patients' records.

Dr. Laughlin added that in his group a physician reviews all notes written by the midlevel practitioners. "The dictation is done one day, and typed up the next, so that within 48 hours we usually have reviewed the assessment and the plan," he said. During the record review, Dr. Laughlin said he searches for inconsistencies, rare diagnoses or unusual treatments. "Anything that wouldn't seem to flow and make sense," he said.

Statistics show the number of PAs in active clinical practice grew in the United States almost 52 percent – from 20,666 in 1991 to 31,300 in 1997 – according to the American Academy of Physician Assistants. The number of nurse practitioners grew about 16 percent nationwide, from 140,000 in 1994 to 161,700 in 1996 (the most recent available data).

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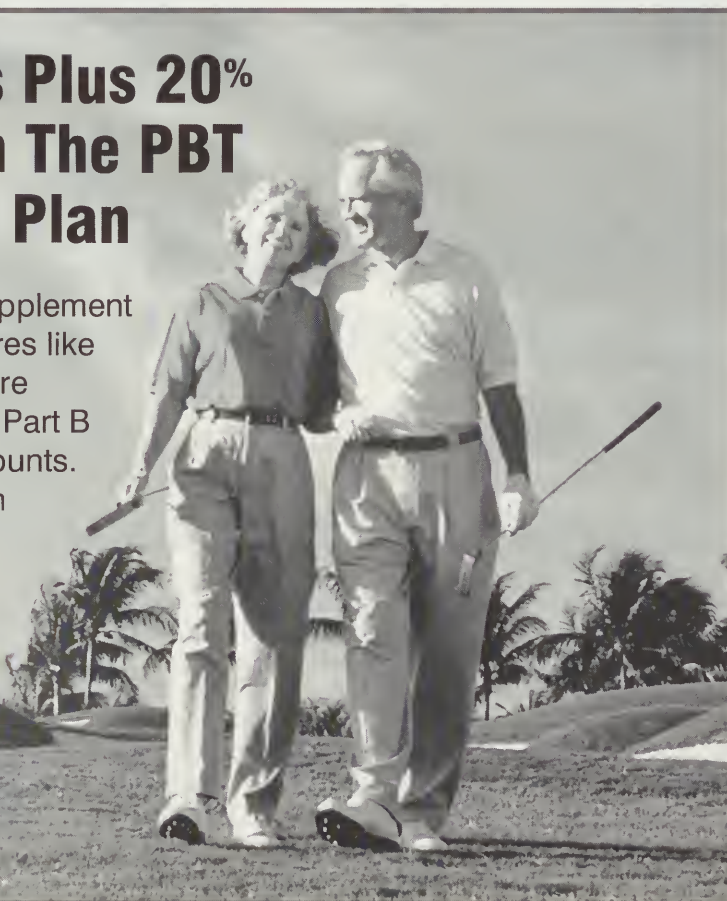
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Physicians must report elder-abuse concerns

BETTER DATA: Trend tracking cited as a secondary benefit. BY JANE ZENTMYER

[CHICAGO] Beginning Jan. 1, Illinois law will require physicians, law enforcement officers and other professionals to report to the state all cases of suspected abuse and neglect of people age 60 or older. The law specifically targets elders who, "because of dysfunction," do not report the abuse themselves.

In 1997, the ISMS House of Delegates voted to support legislation requiring physicians to report suspected senior citizen abuse, one that shields physicians from confidentiality violations for doing so. As part of this policy, ISMS also supports educational programs to help physicians learn about such elder-abuse issues as recognition, screening, referral and reporting.

"Illinois' older population needs and deserves protection against abuse and neglect, especially those most vulnerable who are unable to take action on their own," said Gov. Jim Edgar this summer when he signed the bill that includes the reporting provision. "This legislation strengthens current [elder-abuse] laws."

Patient-physician communications are not privileged in suspected elder abuse cases under the new law, which grants immunity to individuals who in good faith provide information or records for an investigation.

The state defines elder-abuse as any physical, mental or sexual injury, including financial exploitation, to an eligible adult. The new law allows court petitions to freeze seniors' assets to protect them from continued financial exploitation.

Reports of elder abuse have tripled from about 2,500 in 1991 to almost 7,800 this year, according to the Illinois Department on Aging. About 75 percent of the alleged victims are women, with an average age of 78. Three out of four abusers are a spouse, child or other relative.

"Elderly people are often reluctant to report abusive caretakers because they perceive their alternatives, which in many cases may be a nursing home, as worse," said Joan Cummings, MD, a geriatrician network director for the Veterans Integrated Service Network. But abuse investigations do not necessarily end in a family break and subsequent loss of a caregiver, she pointed out. Sometimes abuse stems from the stress of caring for an older person, and if the state is alerted to the problem it can intervene to provide services that resolve the situation.

Reports can be placed 8:30 a.m. - 5 p.m. Monday through Friday by calling the

Department on Aging's Senior Helpline at (800) 252-8966. After hours, and on weekends and holidays, physicians can call (800) 279-0400. IDOA's 47 local elder abuse provider agencies will also accept reports. Appropriate agency locations are available by calling the Senior Helpline.

In addition to its patient benefits, the state will use statistics gathered from

physicians and other providers to track health care trends so that it can better allocate resources.

Elder abuse cases are not the only trend the state plans to track with the help of health care professionals. Earlier this year the Illinois Department of Public Health finalized new reporting rules that health care facilities must use to report victims of violent injuries, and

head and spinal cord injuries.

Health care facilities in these cases include hospitals, ambulatory surgical treatment centers and freestanding emergency centers. Physician and dental offices are not included in this definition and, therefore, do not have to file reports, said Leslie Stein-Spencer, chief of IDPH's emergency medical services and highway safety division.

The data will be used to help estimate the cost of violence to a community and to help the state's emergency medical services systems design prevention programs based on trends in violence, Stein-Spencer said. ■



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REPORT for Illinois Physicians

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*Aggressive therapy includes, but is not limited to: injectable NSAIDS such as Toradol, sumatriptan (Imitrex), zolmitriptan (Zomig), naratriptan (Amerge), or dihydroergotamine-45 (DHE-45). If a favorable response to IV DHE is not noted after 3 doses, IV DHE should be discontinued.

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- IV hydration and parenteral antiemetics as indicated
- Parenteral medications, e.g., narcotics, NSAIDS, steroids, IV DHE
- Adjuvant therapy as indicated, e.g., antidepressants, anticonvulsants, muscle relaxants by the best tolerated route of administration
- Begin maintenance or preventive medications, i.e., beta blockers, calcium channel blockers
- Begin regimen of narcotic/medication withdrawal if patient has an established pattern of overuse

Day 1 or Day 2:

- Initiation of discharge planning
- Instruction in self-management of ongoing or recurrent headache pain
- Instruction in non-pharmacologic pain management techniques

Discharge Criteria

- Improvement in severity of the headache
- Availability of outpatient or ECF treatment of non-life threatening medication side effects, e.g., orthostasis, dizziness, drowsiness

Case Management/Disease Management

- Case Management assessment for patients with exacerbations requiring recurrent admissions, or for patients with significant psychiatric issues
- Referral to an outpatient pain control program if appropriate

Condensed pathway - Full text and references upon request

Issue: 10/30/98 - AMK

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EDITORIAL

“60 Minutes” autopsy report an unkind cut

Despite what viewers of “60 Minutes” were led to believe earlier this month, the declining American autopsy rate is driven by a complex set of circumstances – not medical malpractice.

So it's no surprise many physicians were outraged when the Sunday evening broadcast, laden with inflammatory quotes from JAMA editor George Lundberg, MD, laid the blame for the decline squarely on the shoulders of the medical community's fear of malpractice claims.

With camera tight-on-face in typical “60 Minutes” fashion, Dr. Lundberg gave his take on the issue: “Some hospitals, some medical staffs are afraid to find out what happened in people who died.”

Interviewer Mike Wallace probed further: “And a good many are burying their mistakes?”

Dr. Lundberg's response: “In large numbers.”

It may be simpler for a ratings-hungry news show to boil the problem down to one villain rather than bore viewers with drab evidence detailing the multi-faceted explanation. The medical community does not have the luxury of choosing its scapegoats.

The show implied it was revealing an emergent trend. In reality, the autopsy rate decline is a long-evolving situation. In Chicago, the average permission autopsy rate has been on a downward spiral for

decades, after peaking at 49 percent in 1955, according to a study by the Institute of Medicine of Chicago.

There is a barrelful of reasons. Chief among them is the elimination of the Joint Commission on Accreditation of Health-care Organizations' requirement for a specific autopsy rate. Cost is another consideration. Few insurance companies today see value in care for those who have already died. Another contributing factor is technological advancements.

If physicians or hospitals do something wrong, the guilty should be revealed and disciplined. But it is shortsighted to suggest that widespread use of autopsies is a solution for minimizing medical malpractice.

The medical community must examine this issue thoroughly and work for changes where necessary. ISMS policy already encourages its members to seek approval for postmortem examinations, when appropriate, in all cases of death where the autopsy has public health and educational benefits for medical science, the family of the deceased individual or the public at large.

The good that may come out of the CBS report is that it has stirred informed debate, which will encourage the medical community to heighten public awareness about when autopsies are appropriate, and to not overlook them as important medical-research and quality-control tools.

PRESIDENT'S LETTER

JAMA editor off-target – speaks out of turn

Richard A. Geline, MD



The net effect was a hard slap at the entire medical community.

The old saying that truth is stranger than fiction once again rings true. If I hadn't seen it, I wouldn't have believed it.

You may have seen it too. On Sunday, Oct. 11, Mike Wallace and “60 Minutes” took a couple of anecdotal stories from California, drew from a study in Ohio, pasted in some inflammatory comments from George Lundberg, MD, editor of the Journal of the American Medical Association, and concluded that the declining rate of autopsies represents something nefarious on the part of doctors and hospitals across the country.

The message was that there is a direct connection between the decline in autopsy performance and medical mishaps – that autopsies are purposely avoided to conceal mistakes in care. Hospitals were accused of diverting funds earmarked for autopsies to profits. Risk managers were accused of deceptive practices and cover-ups.

The net effect was a hard slap at the entire medical community. Reflection on the matter brings to mind some questions:

Essentially, was the premise accurate? Presenting little more than statistics from one state, along with abbreviated anecdotal cases from another hardly justifies the conclusion offered. Placed against the known reasons for the decline in autopsies – improved diagnostic technology, family resistance, and the absence of reimbursement for this valid medical procedure – the argument that there is a sinister, self-serving motivation cannot be sustained.

Autopsies are indeed a traditional and valuable educational tool. But the “60 Minutes” conclusion that their decline is due to a medical cover-up or conspiracy is incorrect. The line just doesn't connect.

So given this questionable premise, what is the propriety of having a senior AMA official aggressively presenting such a negative image of the house of medicine? Try as Dr. Lundberg and

the AMA might to say the JAMA editor speaks as an individual, the hard fact is that the connection to the AMA is real. Only insiders will recognize the distinctions in the AMA's chain of authority and who properly speaks for the AMA.

For the general public and even a large segment of the medical community, the word of Dr. Lundberg is the word of the AMA. AMA Chairman Randolph Smoak Jr., MD, tried to do the right thing after the show aired, declaring, “It would be unfortunate if [Dr. Lundberg's] choice of words unnecessarily alarms patients and their families and mistakenly questions the motives and ethics of their doctors.”

Unfortunately, Dr. Smoak's statement may be a case of too little, too late. For organized medicine, the timing of Dr. Lundberg's comments could hardly have been worse. New AMA Executive Vice President E. Ratcliffe Anderson Jr., MD, is fighting to remove the stain of the Sunbeam debacle from the organization, pledging a wholesale change of direction. AMA President Nancy Dickey, MD, is working to inspire a rededication to professionalism in physicians throughout the country.

Here in Illinois, we have just emerged from a wrenching debate over our unified relationship with the AMA. Now the bar of proving the value of AMA membership to our colleagues has been raised. As a longtime AMA supporter and declared advocate of our unification policy, I expected better from someone in Dr. Lundberg's position.

The pathologist/social critic Dr. Lundberg seems to have developed a disproportionate view of this issue, framed by his area of expertise. When all you have is a hammer, the whole world looks like a nail.

This entire episode seems so bizarre that it ought to be fiction. We'll see what the next chapter brings.

GUEST EDITORIAL

HMO liability
is worth the cost

By Mark A. Rothstein

Congressional Democrats and Republicans alike support legislation to revamp managed care and give patients additional rights in the health care system. Both proposals call for easier access to some specialists, coverage of emergency services and procedures for appealing denial of claims. But the bipartisan agreement diverges on whether patients and their families may sue health maintenance organizations for injuries resulting from the wrongful denial of health care. This basic right should not be derailed by worries of higher costs or loss of coverage.

The federal Employee Retirement Income Security Act bars personal injury actions that are "related to" an employee health benefit plan. This means the law permits medical malpractice actions against health care providers based on substandard care, but precludes lawsuits against HMOs that wrongfully deny or delay services. In a recent California case, an HMO delayed authorizing a bone marrow transplant and high-dose chemotherapy for a woman's breast cancer for so long that the cancer spread to her brain and she died before treatment. The court ruled her family could not sue the HMO for damages. This is not an isolated case.

The Democratic proposal in Congress would allow lawsuits for personal injuries. Democrats and some Republicans argue that holding HMOs accountable for their wrongful actions is a matter of basic fairness and good health policy. Injured parties would receive compensation and the HMOs would be deterred from future wrongful behavior.

The Republican proposal would retain the ban on personal-injury lawsuits against HMOs. Republicans argue that permitting lawsuits for personal injuries would increase costs as HMOs authorize additional services to avoid being sued and incurring the costs of litigation. These additional costs will be passed on to employers that purchase health care coverage. Higher costs, leading Republicans argue, will lead some employers to stop covering their employees altogether and will lead other employers to shift additional costs to employees, causing some workers to decline coverage. Thus, the unintended consequence of holding HMOs accountable will be more uninsured Americans.

There is a parallel debate over the minimum wage. Virtually every time there has been a proposal to increase the minimum wage, opponents argued that higher wages will increase unemployment. This is true to some degree (although the amount is always disputed), because a basic principle of labor economics is that as costs increase, demand decreases.

Nevertheless, whenever Congress has raised the minimum wage, it

implicitly has adopted the following rationale: An increase in the rate of unemployment is an acceptable price to pay for ensuring that those who earn the minimum wage will have a decent

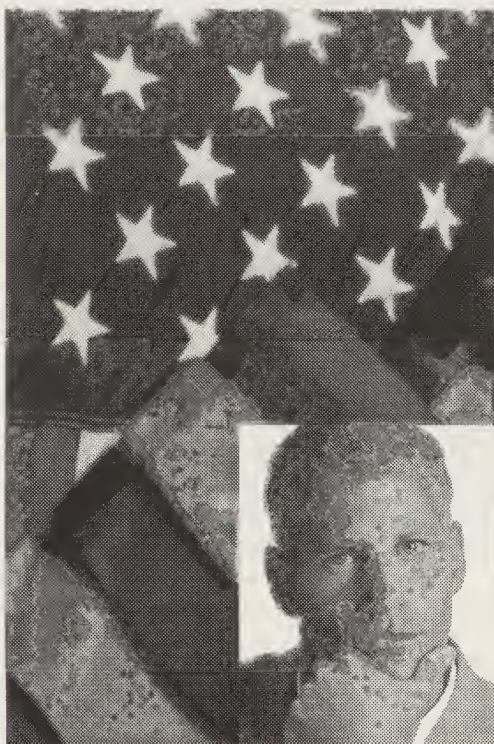
standard of living. At least in theory, the increase in unemployment should be addressed in other ways, such as longer unemployment insurance benefits and better job-training programs.

Apply this theory to health care: As long as health insurance in the U.S. is primarily optional and employer-sponsored, any regulation will result in marginally increased costs and loss of coverage. Yet it is hard to argue against requiring physicians to have medical licenses and for pharmaceuticals to be tested for safety. The benefits of regulation do outweigh the costs.

Essential health care reforms should not be rejected because increased costs result in more people becoming uninsured. A small increase in the number of uninsured is an acceptable price to pay for providing that individuals with health care coverage have a decent level of care.

Mr. Rothstein is director of the Health Law and Policy Institute at the University of Houston.

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ISMIE Update

Balancing courtesy with caution

BY ED FINKEL

Physicians frequently extend professional courtesy to one another, providing drug samples and complimentary medical advice to employees, fellow physicians and their families. From a liability standpoint, taking care of colleagues is no different than taking care of anyone else. Regrettably, malpractice suits can result. When fiscal restrictions are added to the mix, professional courtesy – too often taken for granted – merits a healthy dose of caution.

A chummy relationship shouldn't lead to a casual approach to health care, said Fred Grossman, a partner in the medical malpractice litigation group at the Chicago law firm of Clausen & Miller.

"Problems that exist when you're treating your peers and their families are the same problems that exist when you're treating the general population," he explained. "Just because you're treating another physician doesn't mean you shouldn't record everything. Meticulous record-keeping is always important, the primary priority on any list."

Physicians rarely sue other physicians, Grossman admitted, although their family members are somewhat more likely to. Even that is mitigated to some degree by family members' knowledge of medical

procedures, often gleaned from their physician relatives. A savvy family member is much more likely to recognize and point out problems as they occur rather than complaining later. "Doctors' families are sometimes more sophisticated than the general public," Grossman said.

Sometimes, though, families don't know how much they don't know, according to Sharon

Flint, MD, an Oak Park pediatrician who often sees physicians' children. "Assume nothing," she cautioned. "Physicians may not be as vigilant . . . if one of the parents is also a physician. Sometimes parents will come in and want vaccines. [They say,] 'I'll do the vaccines at home if you just want to give them to me.' We would never do that, because we're responsible. If kids are sick, we always recommend they bring them in instead of just trying to diagnose over the phone."

Beyond liability, billing issues are a subject well worth mastering when it comes to professional courtesy – be it courtesy extended to staff, other physicians, friends or those who are unable to pay for their services. There are several traps to avoid.

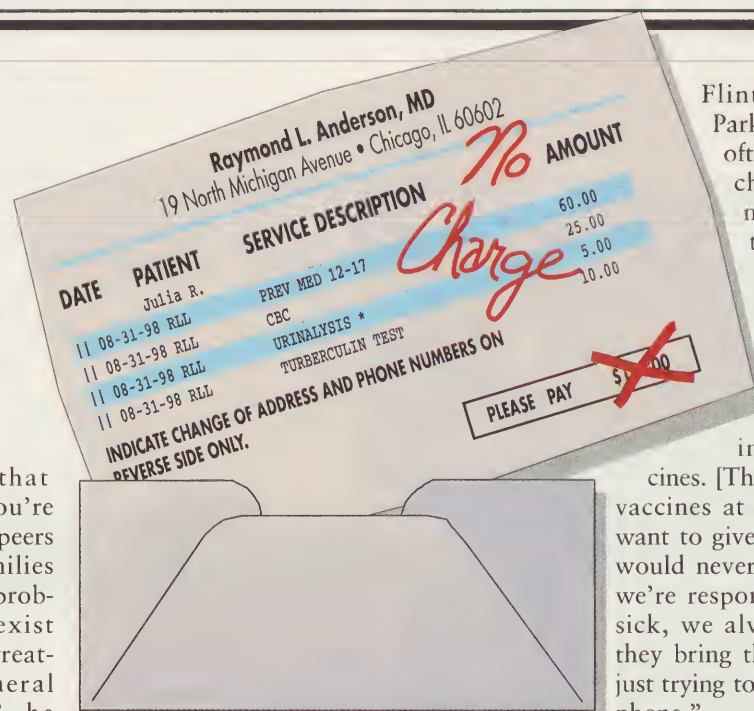
Physicians must understand it is illegal to bill managed care companies for services while waiving the co-payment or deductible for a patient. Not

only do most managed care companies bar physicians from waiving co-payments or deductibles when filing a claim, the Health Insurance Portability and Accountability Act of 1996 levies a penalty of up to \$10,000 per case for such practice.

The government and managed care companies fear waiving such fees while collecting from an insurer could become a devious incentive to over-use services. Even worse, it could look like a kickback. Thus, HIPAA bars physicians from submitting claims to patients' insurers, except in cases of documented financial hardship.

Discounts, lack of charges and referrals also can raise red flags with managed care contracts, and physicians should learn the legal subtleties of each.

Without scrupulous attention to record-keeping and the knowledge of what conforms to contractual terms in insurance policies and Medicare, physicians who mean only to extend their professional courtesy to others may open themselves to liability risk and the legal wrath. ■



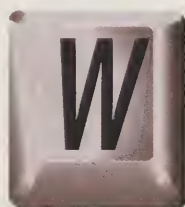
Risky business – a CME reading list

Keeping pace with risk management issues is as easy as an evening read. Investing an hour or two in any of these pieces can quickly and easily hone a physician's risk management awareness, and help meet his or her licensing renewal requirements. Following is a sampling of articles that can be read for CME credit.

- American Thoracic Society. "Withholding and Withdrawing Life-sustaining Therapy." *Annals of Internal Medicine* 115 (15 September 1991): 478-85. [Internal Medicine]
- Berlin, Leonard. "Malpractice Issues in Radiology: Alteration of Medical Records." *American Journal of Radiology* 168 (June 1997): 1405-08. [Radiology]
- Berwick, Donald M. "Peer Review and Quality Management: Are They Compatible?" *Quality Review Bulletin* (July 1990): 246-51. [Peer Review]
- Brennan, Troyen A., et al. "Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I." *New England Journal of Medicine* 324 (7 February 1991): 370-76. [General]
- Brown, Murray, Pranav Shah, et al. "Litigation in Residency Training Programs and Suggested Due Process Guidelines for Residents in Trouble." *Academic Psychiatry* 18 (Fall 1994): 119-28. [General & Psychiatry]
- Fink, Sidney, and Tapan K. Chaudhuri. "Medical Characteristics of 61 Unwarranted Malpractice Claims." *Southern Medical Journal* 88 (October 1995): 1011-19. [Radiology]
- Foley, Kathleen. "Pain, Physician-Assisted Suicide, and Euthanasia." *Pain Forum* 4(3) (1995): 163-78. [Ethics]
- Kearney, Kerry A. "Medical Licensure: An Impediment to Interstate Telemedicine." *ABA, Health Law Section, The Health Lawyer* (9) (1996): 14-15. [General]
- Leape, Lucian L., Troy Brennan, et al. "The Nature of Adverse Events in Hospitalized Patients: Result of the Harvard Practice Study II." *New England Journal of Medicine* 324 (7 February 1991): 377-84. [General]
- Levinson, Wendy, Debra Roter, et al. "Physician-Patient Communication: The Relationship With Malpractice Claims Among Primary Care Physicians and Surgeons." *Journal of the American Medical Association* 277 (19 February 1997): 553-59. [General]
- Localio, A.R., et al. "Relation Between Malpractice Claims and Adverse Events Due to Negligence: Results of the Harvard Medical Practice Study III." *New England Journal of Medicine* 325 (25 July 1991): 245-51. [General]
- Parmet, Wendy E. "Legislating Privacy: The HIV Experience." *Journal of Law, Medicine & Ethics* 23 (1995): 371-74. [Internal Medicine & General]
- Reidinger, Paul. "Fraud Doctors." *ABA Journal* (May 1996): 50-54. [Peer Review]
- Schneider, Carl E. "Bioethics in the Language of the Law." *Hastings Center Report* 24 (July-August 1994): 16-22. [Ethics]
- Walker, RM. "DNR in the OR: Resuscitation as an Operative Risk." *Journal of the American Medical Association* 266 (6 November 1991): 2407-12. [Ethics]

For the July 1999 license renewal, physicians must earn 50 hours of CME. They must earn 20 formal, or Category 1, CME hours and 30 informal, or Category 2, hours. Any hours physicians earn after July 1997 will count toward this 50-hour total.

Tick tock...



With over 100,000 different kinds of medical devices in use statewide, any one of which might – and the operative word is *might* – malfunction on midnight Jan. 1, 2000, any headaches suffered by Illinois physicians could be caused by something other than too much New Year's Eve cheer.

From thermometers to defibrillators, elevators to telephones, patient records to Medicare reimbursements, the Y2K issue has elbowed its way into the consciousness of health care providers. It now stands center stage as a primary concern for physicians everywhere.

And in many ways physicians are currently flying solo when anticipating and addressing Y2K problems that might occur in their practices. While there are various sources of information, especially on the Internet, experts say diligence and detective work on the part of physicians – though time-consuming – is the best approach heading into the new millennium. For better or worse, it falls to individual physicians to discover which pieces of equipment are likely to fail and what manufacturers are planning to do about it.

Generally known – incorrectly – as a “bug” or “flaw,” and often presented as a programming mistake, the Y2K issue is none of the above. High disk-storage costs, the time and expense of inputting data and a belief that computer systems would be replaced well before the year 2000 led programmers to use two-digit fields when inputting years. For example, 96 means 1996 to many computers and microprocessors; therefore, they might assume that 00 – the last two digits of the year 2000 – when inputted, represents 1900 not 2000, and work erratically or simply shut down.

And that's the problem. With billions of tiny clock-bearing computer chips at large in the world, it's potentially a problem of nearly unfathomable scope. For example, in Britain, a government survey estimated that health-related Y2K failures may be fatal for up to 1,500 of its citizens.

While many business sectors here at home are moving forward to ensure their equipment and systems work after Dec. 31, 1999, according to an Illinois State Medical Society white paper, “hospitals and other health care providers are the least prepared ... even though the consequences of not preparing may directly result in harm to patients.”

The ISMS report highlights medical devices and systems in which microprocessors are embedded and which could

Can anyone beat the Y2K clock?

BY JEFF BLACK & LEN STRAZEWSKI

be affected. A greatly abbreviated list includes: patient care devices such as heart-lung machines, defibrillators, drug-dispensing systems and kidney dialysis machines; mechanical systems including elevators, heating and cooling systems, fire alarms and telephones; and other systems like badge readers and pagers.

Discovering whether a particular device is Y2K compliant – i.e., it will not fail when the clock ticks to 2000 – has proved difficult. Product manufacturers, wary of liability issues, are often reluctant to give direct responses when asked to verify their products' compliance. The U.S. Food and Drug Administration has asked approximately 16,000 manufacturers of medical devices to report whether their goods are compliant. As of

Oct. 1, it had heard from only about 15 percent of them, an FDA spokesperson said.

Voicing his anger at a recent U.S. Senate hearing was Sen. Christopher Dodd (D-Conn.), co-chairman of a special Year 2000 committee. “I am deeply disturbed by the fact that instead of taking steps to deal with this problem, the medical device industry, as a whole, seems to be exacerbating the problem by refusing to provide information ... to the FDA.” He warned that “if there isn't more action, I'm afraid the Y2K problem could have this nation's health care system on a respirator come January 2000.”

Gayle Finch, director of the FDA's Office of Information Technology Planning and Investment, said that while her agency has no legal authority to require answers, the federal government is about to turn up the heat on nonrespondents. Names of manufacturers failing to answer the FDA's inquiries will soon be posted on the agency's Web site (see sidebar), where an ever-growing amount of space is devoted to Y2K. There are also legislative moves afoot, she said, to prohibit government agencies from purchasing the products of nonrespondent manufacturers.

“Right now,” Finch stated, “our focus is on obtaining the compliance status of devices. That's our first step in guaranteeing patient safety. That and informing health care professionals and the public of possible

risks.” Only after hearing from the manufacturers – even if the news is bad, that they aren't compliant – can remedial actions take place, she added. “That's when we can begin to find out if there is some way to patch over the problem and if there is a new or replacement product available.”

This can be complicated. More than a year prior to Jan. 1, (Continued on page 8)



Tick tock

(Continued from page 7)

2000, at least 20 lawsuits have been filed against manufacturers regarding compliance issues. Five suits are against a single manufacturer of medical office software. One plaintiff claimed that,

after hearing from the manufacturer that his \$20,000 office system was non-compliant, he was told he could buy an equally expensive, though fully compliant system from them to solve his problem. In his class-action suit, the plaintiff asks that he receive the compliant software for free.

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Finch urged physicians not to rely solely on the FDA Web site or any single outside source for compliance information – and to do investigative work of their own. “Our advice right now to physicians is that they take advantage of existing customer-supplier relationships. You can’t replace those. Use them to get as much information as you can about the compliance of your equipment. Right now, our Web site is just another resource. Use it to compare the information you get on your own.”

And don’t be surprised if there’s a hefty price tag attached to the solution. Some estimates of the cost of the nation’s total compliance – if achievable at all – top \$1 trillion.

As a former computer programmer, Joel Ackerman unwittingly helped create the Y2K problem. Today, he is executive director of the Minneapolis-based Rx2000 Solutions Institute, a health care industry consulting company specializing in Y2K. Ackerman described Rx2000 as an “independent, nonprofit, membership-supported organization” with the sole objective of ensuring “the survival of health care organizations into the next millennium with minimal impact on patient care.” Extensive information and answers to frequently asked questions about Y2K appear on Rx2000’s Web site.

Appearing before Sen. Dodd’s committee, Ackerman gave his recommendations of what the federal government and health care community should do regarding Y2K. Some of those recommendations included aggressively maintaining a critical sense of urgency, providing financial assistance to smaller health care organizations and considering limitations on Year 2000 liability only for responsible organizations.

If the Y2K issue involved only medical devices and other hardware, it would be bad enough. But it extends into every aspect of providing quality health care, including the basics of a physician’s office practice. Experts say that, on this level, small offices may be affected the most. And electronic billing may be the biggest problem they face. If billing sys-

tems and managed care payers are not both Y2K-safe, bill payments could be lost, delayed or destroyed, said managed care technology expert David Stachoviak, program manager with CBSI, Inc. of Schaumburg.

“Even the simplest spreadsheet or accounting program is built around dated information. If your accounting system – or the system used by your insurance or managed care claims payer – is not Y2K-safe, claims may not be paid,” he said.

As if to prove Stachoviak’s point about the interdependency of organizations when confronting the Y2K issue, the U.S. Health Care Finance Administration in Washington recently announced plans to delay payment updates and routine changes in its automated system beginning Oct. 1, 1999. The delay, the agency said, is designed to allow time for Medicare contractors to be tested for Y2K safety.

But HCFA – with 49 million lines of computer codes to be checked – has Y2K problems of its own. The agency was blasted by a congressional subcommittee for its flagging compliance efforts. HCFA officials apologized for being only one-third of the way to total compliance.

“It is incomprehensible to me,” one ranking – and rankled – subcommittee member said, “that this Y2K problem has gotten so far out of hand.”

Meanwhile, the millennium clock keeps ticking . . . ■

Y2K Online

The following Internet addresses can lead physicians to more information and insight on the Y2K issue. But, experts advise, when it comes to discovering the compliance of your equipment, nothing yet beats physician contact with equipment manufacturers and good old-fashioned hard work.

www.ama-assn.org – A broad online overview of Y2K issues developed in collaboration with the American Medical Association’s campaign, Moving Medicine Into the New Millennium: Meeting the Year 2000 Challenge.

www.fda.gov – Although FDA officials don’t want this site to be a physician’s only Y2K source, it has a wealth of information, including a Biomedical Equipment database that – supposedly – reveals details of manufacturer compliance.

www.ha.osd.mil/hpy2K2.html – This U.S. Department of Defense Military Defense System’s no-nonsense Web site providing Y2K guidance and links at “awareness assessment, renovation, validation and implementation.”

www.hcfa.gov – The grain of salt to take with this site is that HCFA is under the gun itself for falling behind in compliance efforts. However, here’s a way to keep up with how Y2K might impact Medicare reimbursement.

www.Rx2000.org – A Year 2000 “information clearinghouse,” this Web site, a service of a Minneapolis-based not-for-profit, offers all things Y2K to members and non-members alike.

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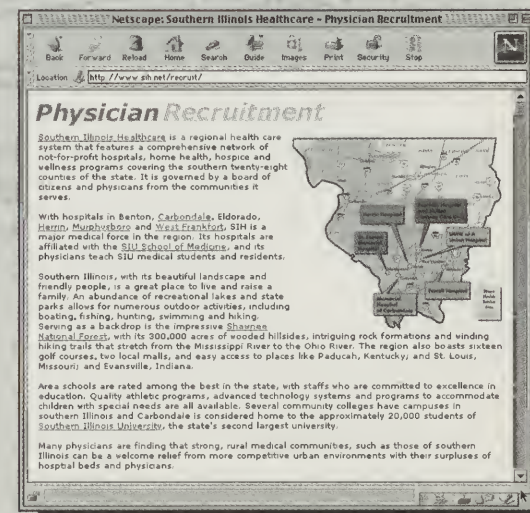
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SOUTHERN ILLINOIS HEALTHCARE



Texas decision

(Continued from page 1)

tion laws provide for virtually every other industry in the nation. Only a federal law can provide that guarantee."

In response to a call for help from the American Medical Association, Dr. Geline, ISMS President-elect Clair Callan, MD, and past chairman of the ISMS Board of Trustees M. LeRoy Sprang, MD, traveled to Washington D.C. in July, lobbying members of Congress to include provisions that eliminate ERISA in patient-rights legislation being developed.

Texas attempted to resolve the ERISA

debate locally by eliminating the exemption from state medical malpractice laws in a 1997 managed care reform bill. Soon after passage, it was challenged in the U.S. District Court for the Southern District of Texas, Houston division, by subsidiaries of Aetna Life & Casualty Co.

However, U.S. District Judge Vanessa Gilmore ruled that ERISA doesn't preempt a state's right to regulate public health and safety. The Texas law, she concluded, regulates the quality of the benefits provided to patients — not the type of benefits offered, nor the way benefits are administered.

The district court also struck down

the part of the law that created an independent review process, ruling it interfered with the administration of employee benefits, as well as provisions that prohibited plans from retaliating against physicians and held physicians harmless for a plan's actions.

With the judge's decision to uphold the Texas law, Aetna said it will seek an implementation delay so it can try to salvage the review process. Aetna said it would like to craft a revised review mechanism that would survive an ERISA challenge. The Texas attorney general's office has agreed "in principal" to work with Aetna.

Reformists

(Continued from page 1)

Such opposition is critical, maintained Dr. Peeno, who currently works as an expert witness in managed care litigation. "Managed care's grip on medicine continues to tighten," she said, "often without widespread awareness."

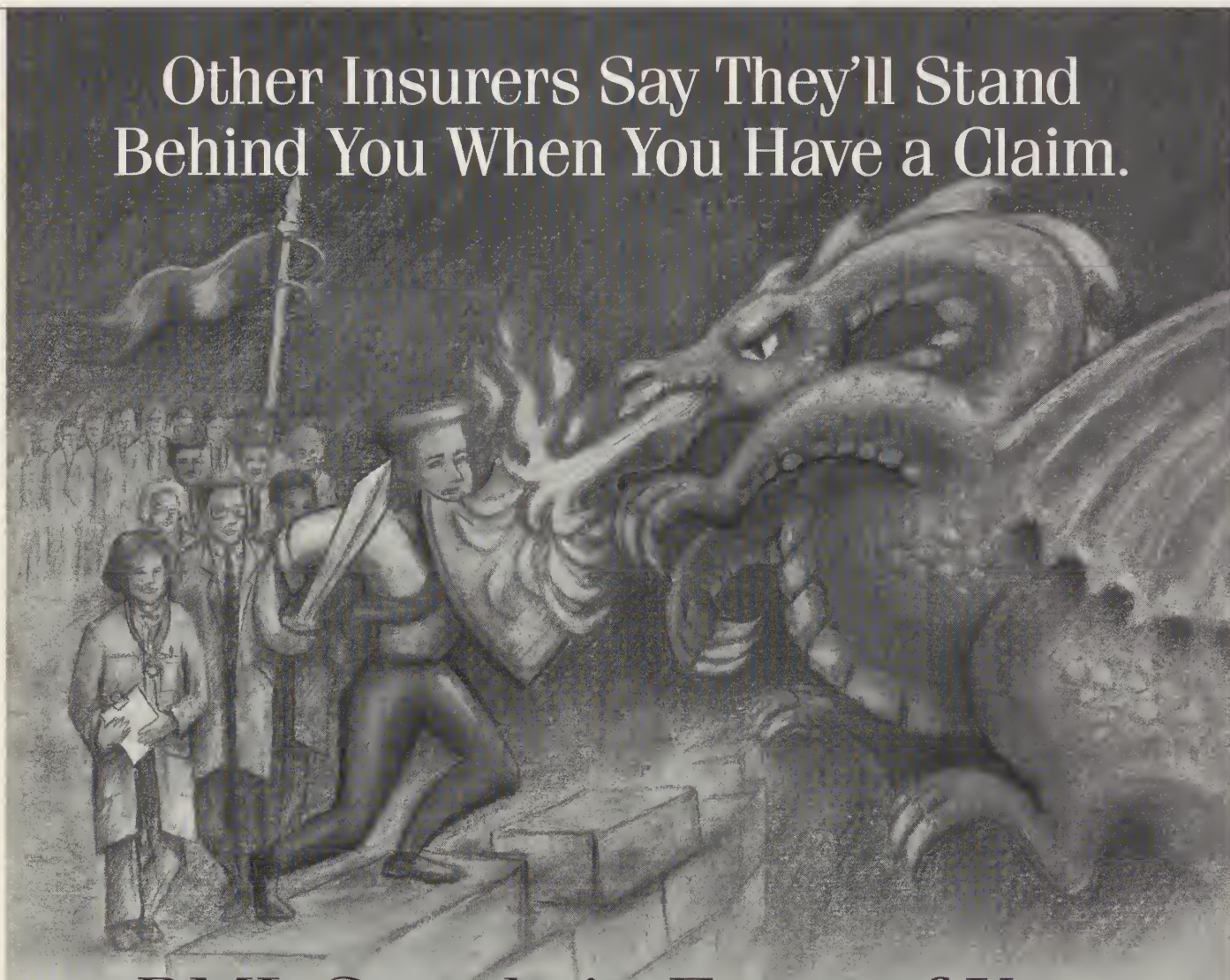
Another crusader at the event, New England Journal of Medicine editor-in-chief emeritus Arnold Relman, MD, said he believes the current system of managed care will not last, because it pits the interests of third-party payers against those of patients and infuriates and ensnares the medical profession. Nevertheless, in Dr. Relman's opinion, it is inevitable that some form of managed care will be here for decades to come. So the questions remain: "Who will do the managing? For whose benefit?"

"Managed care totally neglects the community function, the education function and the clinical research function [of medicine], without which you do not have a health care system," said Dr. Relman, a professor of medicine and social medicine at Harvard Medical School, Cambridge, Mass. A viable alternative, Dr. Relman suggested, would be for the public and private sectors to work together in a non-profit system.

Physician involvement is critical to the success of health care reform, he said. "Without the cooperation of physicians, no major health care reform can take place," said Dr. Relman, noting that lack of physician involvement helped derail the Clinton administration's health care reform proposals in 1994. "Doctors have to be part of the solution."

"It won't be easy to make these changes," he concluded. "But changes will have to be made."

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Shellfish warnings

ELECTION OUTCOMES



George Ryan



Peter Fitzgerald

Now that Republican Secretary of State George Ryan will kick off 1999 with a new job – governor of Illinois – physicians here will gain a valuable champion in Springfield. In fact, Ryan's campaign themes emphasized health care issues such as tort and managed care reforms.

Illinois voters chose Ryan as their next governor Nov. 3 after a bruising election fight against U.S. Rep. Glenn Poshard, a Downstate Democrat. Ryan received 52 percent of the vote, compared with 48 percent for Poshard.

As governor, Ryan has pledged he would help state legislators pass a tort reform package. He had strongly supported the 1995 tort reform law that the state Supreme Court ruled last year was unconstitutional.

(Continued on page 10)

Conference sheds light on emerging infectious diseases

PUBLIC THREATS: Terrorism, emergence of drug-resistant infections, food-borne illness and influenza are on the watch list.

The medical community must take an active role in combating emerging infectious diseases. That was one of the key messages delivered during Emerging Infections: Global Challenges ... Local Solutions, a summit held last month in Chicago.

"We can't be complacent about these diseases, which are the third leading cause of death in this country after heart disease and cancer," said Shari L. Bornstein, MD, chief of infectious diseases for the Illinois Department of Public Health, which co-sponsored the summit with the American Association for World Health.

The concept of emerging infectious diseases includes newly identified infectious diseases as well as older viruses that are reemerging. Myriad societal, technological and environmental factors explain why an increasing number of infections are emerging in this country, Dr. Bornstein said. Among them is

the global economy that brings food, people and agricultural products from other places. "The economy acts as a vehicle for importing infectious diseases that we don't usually think of occurring in the United States," she said.

Other culprits are the misuse and overuse of antibiotics in agriculture and medicine, which are leading to increasing numbers of drug-resistant organisms. Conference speakers emphasized the importance of physi-

(Continued on page 13)



Andrew Corrigan Halpern

John Lumpkin, MD, director of the Illinois Department of Public Health, speaks on building public/private partnerships around emerging infectious diseases at a recent summit to address local solutions to the growing problem of emerging infections.

Congress stalls on patient rights bill

LOOKING AHEAD: ISMS and AMA prepare for next year's battle. BY JANE ZENTMYER

Despite encouraging predictions of passage earlier this year, a federal patient rights bill became a casualty of partisan delays and presidential scandals when Congress adjourned in October without reaching a compromise.

"This issue did not get the attention it ordinarily might have," said Thomas Reardon, MD, president-elect of the Amer-

ican Medical Association. "That's a shame because the American people have clearly said in all the political polls that it's their number-one issue. They need help dealing with a complex health care system and, in particular, managed care companies."

The patient rights debate will pick up speed again in 1999, Dr. Reardon predicted. The AMA plans to spend the upcoming months working with state societies and others to map out its legislative strategy for the next congressional session.

"ISMS will continue to help the AMA fight for a patient rights bill at the federal level while the Society works to pass a similar bill at the state level," ISMS President Richard Geline, MD, said. "Our patients need a law that ensures they receive quality care."

Dr. Geline, ISMS President-elect Clair Callan, MD, and past ISMS Board of Trustees Chairman M. LeRoy Sprang, MD, (Continued on page 13)

Two Illinois Supreme Court rulings impact physicians

BY JEFF BLACK

In rulings significant to physicians, the Illinois Supreme Court recently clarified the parameters of "fear of contracting AIDS" claims and upheld the validity of physician liens.

Court defines allowable AIDS claims

ISMS General Counsel Saul Morse said the AIDS ruling makes it abundantly clear that "people can't file a lawsuit just because they're afraid." Morse acknowledged that it is hard to know how significant the ruling ultimately may be. However, he added that although the ruling was "very specific to AIDS, there is clearly the possibility that, using similar logic, it will be extended to other infectious diseases."

The court's single ruling on

the AIDS issue came on two similar, consolidated cases. In one, the plaintiff claimed she cut her hand on a podiatrist's scalpel while performing cleaning duties. Seven months later, the podiatrist died of an AIDS-related illness. In the other AIDS case, six plaintiff patients filed a complaint containing 12 counts – including intentional infliction of emotional distress – against Northwestern University, Chicago, and a dental student

who tested positive for HIV.

In both cases the court found that a plaintiff cannot bring a lawsuit against physicians or other health care providers for a fear of acquiring AIDS unless they can show they actually were exposed to the HIV virus.

In the case involving the office worker cut by the scalpel, the plaintiff and her husband – neither of whom tested HIV-positive – sought damages, including for her fear of con-

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INSIDE

And the winner of this year's Stritch Medal is...

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Joan Cummings, MD, to receive Loyola's top honor

Loyola University Chicago Stritch School of Medicine has awarded its highest honor, the Stritch Medal, to an alumna with a distinguished career in the U.S. Department of Veterans Affairs. Joan Cummings, MD, network director of Veterans Integrated Service Network 12 of the U.S. Department of Veterans Affairs Great Lakes Health Care System, will receive the award at a black-tie gala to be held Nov. 20 at the Chicago Hilton and Towers.

"Joan Cummings knows where the health care industry is headed and she keeps one step ahead."

— Dr. Anthony Barbato

According to Anthony Barbato, MD, president and chief executive officer of Loyola University Health System, the prestigious award is being presented to Dr. Cummings in recognition of her "skills as a physician and clinical educator, ascendancy as a senior administrator in the nation's largest integrated health system and continued support of, and dedication to, Loyola University, its school of medicine, and its medical center."

The Stritch Medal is awarded annually to an outstanding alumnus or faculty member of Loyola. Dr. Cummings is a 1968 graduate of the Stritch School of Medicine.

"Joan Cummings knows where the health care industry is headed and she keeps one step ahead," said Dr. Barbato.

Dr. Cummings began her career at the VA as a resident and rose through the ranks to achieve one of its top posts. In leadership positions at the Edward Hines Jr. VA Hospital, she established its first hospice unit and helped develop methods of health care delivery a decade before

they gained widespread popularity in the industry.

For example, as director of hospital-based home care, she worked with a team of care givers, including nurse practitioners, to study how to provide cost-effective home care services. Dr. Cummings was promoted to hospital director at Hines VA in 1990. In 1995 she became the first network director of a region extending into five states.

Dr. Cummings was further praised for being active with ISMS. Her accomplishments include being the first woman elected speaker of the House of Delegates, where she managed an assembly of hundreds of delegates working together to frame ISMS' policy language.

In a recent telephone interview, Dr. Cummings was asked to elaborate on her assessment of health care today and her vision of how it can improve tomorrow. Calling on more than 20 years of experience in the VA, Dr. Cummings believes a refocus on home care can provide both patients and physicians with a host of benefits.

"We need to re-engineer ourselves so the patient is at the core of what we do," Dr. Cummings explained. "The question we must constantly ask is: What are we doing to benefit the patient?"

Dr. Cummings added that when working in the VA environment, it became apparent that many health care services are more suitable in the home — house calls, for example. "Move ser-



Andrew Corrigan Halpern

"We need to re-engineer ourselves so that the patient is at the core of what we do," said 1998 Stritch Medal recipient Joan Cummings, MD.

vices to where the patient needs them — that's where we need to go," she said.

When asked how she would define the duty of physicians in this evolving health care environment, Dr. Cummings highlighted a course of responsibility. "I think [physicians] must recognize the change in expectations of the physician/patient relationship. As physicians, we are still not communicating well enough with our patients to determine what they need and how to get it."

As a solution, Dr. Cummings sug-

gested that physicians take the lead in maximizing medicine's ability to transfer information to the patient. The objective, she said, is to translate the jargon of medical science into a language relative to each person's health decisions. ■

HCFA "severely behind schedule"

The U.S. Health Care Financing Administration may be swamped with work, but it is physicians and Medicare beneficiaries who are most likely to feel the impact, according to the General Accounting Office.

Health policy experts in and out of Congress recently articulated their mounting concern that, because of a flood of new responsibilities, HCFA will miss deadlines for money-saving, modernizing changes scheduled to take effect over the next two years. Threatened with delay are physician reimbursement and a reduction of co-insurance paid by the elderly.

A report by the GAO, the investigative arm of Congress, revealed that HCFA's new duties "appear to be outstripping its capacity to manage its existing workload" and that Medicare officials are "severely behind schedule" in getting the agency compliant with computer adjustments designed to correct the year 2000 "bug."

The escalation of work comes in large part as a result of the Balanced Budget Act of 1997, which created new health insurance options for the elderly, scheduled to begin Jan. 1. ■

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For some, raw or undercooked shellfish can net real trouble

PHYSICIAN ALERT: Campaign pinpoints heightened danger to high-risk patients. BY ED FINKEL

Raw or undercooked shellfish can be fatal in very short order for patients with certain types of diseases, according to the Illinois Department of Public Health and the Interstate Shellfish Sanitation Conference, which are collaborating on a statewide public-information campaign.

According to the IDPH, the vibrio vulnificus bacterium, while only mildly harmful to most patients, has resulted in a mortality rate of slightly more than 50 percent among those diagnosed who also have liver disease, alcoholism, hemochromatosis, AIDS or HIV, diabetes mellitus, gastric disorders, inflammatory bowel disease, cancer or steroid dependency.

Between 1989 and 1996, the U.S. Centers for Disease Control and Prevention reported 149 serious illnesses related to the bacterium, resulting in 75 deaths.

*Death for people
in these high risk
categories usually
occurs within two days
of exposure
to the organism.*

To thwart those serious statistics, the IDPH and ISSC started an information campaign, including a fact sheet for doctors and patients, which contains detailed information on environmental causes, treatment and prevention of vibrio vulnificus.

The ISSC, in its pamphlet The Risk of Eating Raw Oysters or Clams, explains that vibrio vulnificus infections occur not only from eating raw and undercooked oysters or clams, but also when cuts, burns or sores come in contact with seawater containing the bacterium.

Illnesses resulting from this contact can include primary septicemia and gastroenteritis. Wounds that come into contact with contaminated seawater can become dangerously infected.

Death for people in these high-risk categories usually occurs within two days of exposure to the organism. This emphasizes the limited effectiveness of treatment and the importance of prevention.

While the presence of vibrio vulnifi-

cus can be determined through routine procedures, the ISSC urges physicians to notify laboratories when they suspect infection so a special growth medium can be used to improve diagnosis.

The ISSC also cautions persons classified as high risk or with cuts, burns or sores to avoid contact with seawater—particularly in warm bodies of water like the Gulf of Mexico, and especially in summer. It also insists that high-risk

people ensure any shellfish they eat is cooked thoroughly, boiled, simmered or fried in oil for at least three minutes, or baked for 10 minutes. Live oysters or clams in the shell should be boiled for three to five minutes *after* the shells open; any that do not open should be discarded.

IDPH has begun tracking outbreaks of a similar bacterium, also contracted from shellfish, that have plagued resta-

urant patrons in Texas, New Jersey and New York. Like vibrio vulnificus, it is rarely life-threatening, except among patients with liver problems or weakened immune systems.

To get the information kit on vibrio vulnificus, which includes a short survey form, contact IDPH at (217) 785-2439. To obtain the ISSC pamphlet The Risk of Eating Raw Oysters or Clams, call (803) 788-7559. ■



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EDITORIAL

Health care reform requires cooperative effort

Like a frustrated patient attempting to wrangle justified insurance coverage, Americans have been pleading for Congress to pass legislation that will give them a fair shake from their managed care companies.

As part of a nationwide show of strength by organized medicine, three ISMS representatives were among the physician advocates knocking on congressional doors last July to lobby for a patient rights bill.

Politicians seemed to have received the message earlier this year when both parties churned out patient rights proposals that addressed patient and physician concerns.

But the optimism accompanying that fanfare was premature. Congress adjourned last month without passing any of the managed care reform plans that were set on the table.

The excuses are plentiful: Monica-gate left no time for other matters and defused President Clinton's political power to force congressional action. Republicans said the Democrats wanted a campaign issue, but not true reform. Democrats said the GOP was sidetracked by big money and special interests.

Undoubtedly, this issue will return in the 1999 Congress, which means that now is the time to evaluate what went wrong so it doesn't happen again. One clear lesson from this year's attempt at

reform is that if Republicans and Democrats don't work together, it ain't gonna happen.

Real reform means patients can use layperson standards to judge when they need emergency room care without worrying that their insurance company won't cover the bill; it means physicians can advocate for patients without fear of retaliation; it means patients denied treatment can appeal the decision.

One main sticking point between the two political parties is leaving or yanking the Employee Retirement Income Security Act exemption from state medical malpractice laws, which lets managed care companies off the hook when their decisions harm patients. Real reform must provide some measure of accountability for wrongful actions.

Judging by the election rhetoric, politicians understand that patient rights reform is important to voters. It's a shame that Congress did not back up its campaign promises. In the meantime, patients affected by managed care abuses lay in the path of congressional delay.

Organized medicine has no intention of backing off this issue, and ISMS will continue to prod legislators to do what is right. Members of Congress from both parties must check their partisan politics at the door and give their constituents the health care assurances they deserve.

PRESIDENT'S LETTER

Are physicians ready to wear the union label?

Richard A. Geline, MD



Accepting or rejecting the concept of physician unions is not an easy call.

As the managed care experiment continues, the marketplace is changing and coalescence of organizations through mergers and acquisitions has become the rule of the day. According to Crain's Chicago Business, more than two-thirds of all of Chicago's HMO patients are found in just four organizations. And two of those four recently planned a merger; only market conditions prevented it from occurring and concentrating the marketplace more intensely.

The trend has created a climate of unrest. Throughout medicine, physicians have a sense of powerlessness and disenchantment. Frustration rises over the loss of decision-making power and control over the quality of patient care. Serving patient needs has become increasingly difficult in an environment driven by bottom-line financial goals.

Increased patient loads leaving less time to spend per patient, complicated referral processes, gag clauses and late payments are only a few of the elements fueling our frustration.

Against this backdrop physicians from all practice settings – employed, solo, small groups and large groups – are showing increased interest in collective action through formal union organization, acting under the body of law that regulates labor-management relations.

Two questions come to mind. First, considering the implications, do we really want to do it? Second, in view of current laws, rules and regulations, can we do it if we want to?

Answering the first question requires inspection of our own professional makeup. Physicians have an obligation to hold patients' interests paramount. Regardless of practice setting, we have an intrinsic and dominant commitment to serve those in need of our special knowledge and skills.

The major union weapon is the withholding of services – the strike, be it formal or "wildcat." But our long-established policy prevents us from withholding medical services or interfering with the public welfare as a bargaining mechanism. Our moral commitment as physicians mandates "patient needs above our own." The strike is thus unavailable to us as a means to even the most public-spirited of ends.

One economist maintains that it is usually the noncombatant who suffers the most during a strike, and protesting to uphold patient interests does not warrant sacrificing patient welfare even on a temporary basis. Those who strike supposedly on behalf of patients lose credibility in the eyes of the profession and the public by momentarily undercutting the well-being of the people they have sworn to serve.

Looking from another point of view, noted economist Uwe Reinhardt points out that union activity can lead to higher costs, which would drive hospitals and HMOs to cut expenses by reducing their use of physicians.

Beyond the strike, however, there are several measures available to physician unions that do not threaten essential patient care. These include a concerted suspension of paperwork, a slowdown of elective care, informational picketing, nondisruptive public demonstrations, lobbying, public campaigning and collective negotiation, all of which can be instrumental in bringing political and economic pressure to bear on the goals of patient care and public policy.

Either way, accepting or rejecting the concept of physician unions is not an easy call. Each of us will make our own decisions if and when the time arrives.

In my next letter I will address the second question: Can we unionize if we want to?

GUEST EDITORIAL

Quality and cost containment: An unlikely pair?

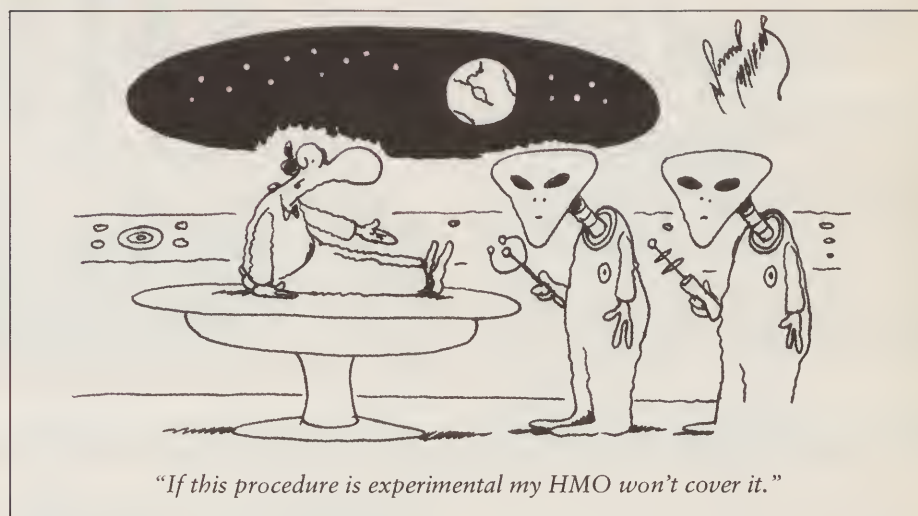
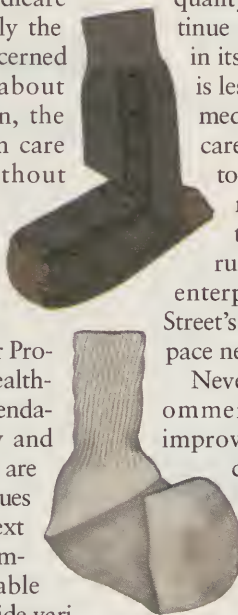
By Emery Wilson, MD

For the past decade, cost containment was the major public issue with health care. Concerns about medical costs were driven by businesses looking to reduce their health care spending and by government trying to reduce spending on the massive Medicare and Medicaid programs. Only the physicians seemed to be concerned about quality. Yet talking about quality was never in fashion, the assumption being that health care costs could be reduced without jeopardizing quality.

Physicians now must brace themselves for a flurry of public concern over quality. Recently, the President's Advisory Commission on Consumer Protection and Quality in the Health-care Industry reported recommendations that emphasized quality and consumer protection, and these are likely to be hot health care issues in Washington, D.C., for the next few years. Specifically, the Commission has identified avoidable errors in medical judgement, wide variation of care among individual physicians and communities, and overutilization or underutilization of services in managed care as areas for concern.

Behind this consumer unrest are some disturbing trends. Relentless pressure to control costs was a key factor behind poor outcomes and a decrease in patient satisfaction. Although there may be a few bad doctors, the physicians who provided quality care before managed care continue to practice by the same principles in its heyday. But working against that is less time to keep up with changes in medical practice, less time for patient care, more time that must be devoted to paperwork, and, in many cases, more attention that must be paid to the finances associated with running a for-profit, investor-owned enterprise. Once medicine joins Wall Street's race for increasing dividends, the pace never slackens.

Nevertheless, the Commission has recommended six national aims for improvement: reducing the underlying causes of disease, injury and disability; expanding research on new treatments and evidence of effectiveness; ensuring the appropriate use of health care services; reducing health care errors; increasing patients' participation in their care; and addressing the oversupply and undersupply of health care resources.



The federal government has formed two agencies to establish national visibility and promote an agenda for quality improvement. Politicians have tired of talking of cost containment, so that "problem" will disappear. "Fraud and abuse" is the current Washington buzz word. Quality of health care is next. Expect to see national objectives for the improvement of health care, more information becoming available to the public on quality of care, and standardized methods of reporting quality. The Consumer Bill of Rights and Responsibilities recently introduced by the President and Congress provides a list of patients' rights in dealing with physicians and managed care entities.

Certainly no one, least of all physicians, is opposed to quality health care. What physicians oppose is the idea that, some-

how, quality of care can be separated from the profound changes cost containment is making to the medical landscape – a diminishment of the doctor/patient relationship, increased administrative paperwork, and other issues which relate to the caring of others. At some point, we can only hope that there are voices of sanity among leaders in medicine as well as state and federal governments that emphasize an appropriate balance between the quality and costs of health care.

Emery Wilson, MD, is Dean of the College of Medicine at the University of Kentucky.

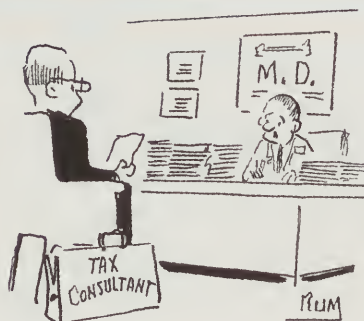
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LETTERS

Insurance invasion

In reference to your cartoon in the September 18, 1998 issue of *Illinois Medicine*, a more appropriate [caption] would include the [following] modifications: "Actually I'm self-employed – but I spend most of my time reporting to the insurance companies." Insurance companies today are more invasive of our freedom than the government.

Leigh E. Rosenblum, M.D.



Actually, I'm self-employed – but I spend most of my time reporting to the government.

Wanted: Dermatologist

The OSF Medical Group, located in Peoria, Illinois is seeking a BC/BE Dermatologist to join their multi-specialty physician practice. This position requires familiarity with the development of a new practice, good public speaking skills and the ability to build consensus and relationships with the medical group and in the community.

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Medical inflation back in driver's seat, says HCFA

Whatever small success managed care has had controlling health care costs is about to come to a screeching halt, according to recently released government figures. The data project national health spending will balloon from \$1 trillion in 1997 to \$2.1 trillion by 2007 – an increase of more than 100 percent. Spending per person will jump from \$3,759 to \$7,100.

The projections, released by the U.S. Health Care Financing Administration's Office of the Actuary, show that health expenditures over the next decade will grow at an average annual rate of 6.5 percent. From 1993-1996, the average annual rate was 5 percent.

Over the last few years, private-sector health spending grew much more

slowly than public-sector – 2.9 percent annually versus 7.5 percent. However, beginning in 1998, the trend is predicted to reverse. HCFA's figures indicate that while public-sector annual growth rates will drop to 5.7 percent, the private sector's annual spending increase will skyrocket to 7.2 percent.

Ironically, analysts say the inflation, at least in part, will be fueled by the very changes wrought by managed care to control costs – specifically ambulatory patients being prescribed medicine in lieu of seeing specialists or checking into a hospital.

Americans are predicted to spend

\$171 billion in 2007 on evermore expensive prescription drugs; in 1996 the expenditure was \$62 billion.

Today, 85 percent of Americans with private insurance are in some form of managed care. The HCFA study said the nation has already gotten its one-time savings from the switch to less expensive medical arrangements.

Though in recent years employers have switched to managed care, looking for the least expensive plan available, HCFA's chief actuary, Richard Foster, concluded that "this can only go so far."

Illinois legislator among Davis Award winners

An Illinois state legislator is among the 10 government leaders picked this year to receive the American Medical Association's annual Dr. Nathan Davis Award, which honors achievements improving the health of Americans.

Nominated by the Peoria Medical Society, State Rep. David Leitch (R-Peoria) was recognized for initiatives he championed in the General Assembly, such as requiring insurance companies to cover mammograms, hemophilia program funding, creation of a brain injury treatment program and liability exemptions for physicians who provide free community-clinic service.

Named for the AMA's founder, the Davis Awards are given to national, state and local government officials who have "promoted the art and science of medicine and the betterment of public health." Winners are selected by an independent panel of judges.



Rep. David Leitch

Rush, United HealthCare go their separate ways

Rush-Presbyterian-St. Luke's Medical Center and financially ailing United HealthCare are calling their relationship quits. As in many troubled marriages, the problem is money – although in exactly what way depends on who is talking.

A spokesperson for Rush's physician-hospital organization complained that neither physicians nor the hospital were being paid in a timely manner, and that patients were "being hassled over payment issues." United HealthCare said the issue was one of reaching a negotiating impasse with Rush while trying to reduce rates and provide customers with low-cost services.

The result, regardless of the reason, is that more than 800,000 United plan participants have had their access to the Chicago hospital terminated.

In August, financial questions helped derail a planned United HealthCare merger with Humana. That same month, United raised eyebrows in the business community with a \$900 million restructuring charge and the elimination of 10 percent of its 800-member workforce in order to lower administrative costs.

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ISMIE Update

Coming soon:
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surgery risks

Making the best stand

A defendant's demeanor can make or break a case.

BY JAY FERRARI

It's an intimidatingly frequent circumstance, one that causes many physicians to stare at the ceiling in the middle of the night: a reputable medical professional is challenged with a malpractice suit. Whether or not the charge has merit, it's a palms-sweating, tension-mounting experience.

To prepare for a pending trial, most defendants first develop a checklist of needs. High on the list are a first-rate legal team, stacks of well-kept procedural documentation, and expert witnesses to testify on the defendant's behalf. Shouldn't that be enough to win a case?

Maybe not, say attorneys who defend physicians in malpractice lawsuits. A physician's best weapon may be his or her own courtroom presence – the ability to come across with a demeanor and courtesy that makes a good impression on a jury. A poor disposition radiates from the witness stand, and almost always colors the jury's verdict, experts say.

So before finding themselves squirming on the witness stand, physicians should take stock of how they can best present themselves. Experts say there are some basic tips a physician should follow. For example,

even a strong case can deflate simply because the physician on the stand won't look at the jury, said Robert Waller, attorney at the Belleville law firm Neville, Richards, DeFranco & Waller.

"The best witness makes eye contact with the jury, in a natural fashion," Waller said. He described that look as one that does not make the jury uncomfortable as if they were being stared at, but lets the jurors know that they – not the judge, bailiff, court reporter, or any of the lawyers – are the focus of the conversation.

In addition to eye contact, good performance under cross-examination includes commonsense civility. "The best witness concedes graciously what he or she has to concede, and is courteous to a fault, even when a lawyer is being rude," Waller said. But he added that good witnesses, acting on their attorney's advice, will also "fight tenaciously for the core principle of testimony."

It is also important to make sure complex medical language is presented in layperson terms. "The best witness gears communication to an understandable level," Waller explained. For example, he said a medical wit-

ness should use the term "broken bone" instead of "fracture."

Attorney Bob Baron of Rooks, Pitts & Poust, in Joliet, reinforced the importance of language. "The best witnesses have thought about the language they will use prior to their testimony. And this requires a good grasp of the case itself."

Baron explained that it is the lawyer's responsibility to make sure his or her physician clients understand the issues of the case. Thus armed, the physician will be able to offer precise testimony. Thorough understanding of the

Dave Cutler/SIS

case also ensures the witness is comfortable, increasing the odds that he or she will be able to come across well to the jury.

A witness with an engaging personality is an obvious advantage, but not crucial to a strong presentation, Baron added. But when dealing with a witness who lacks flair, Baron advises him or her to not make their delivery look too rehearsed. "Essentially, the rules of thumb are to be well prepared, respond in a direct, pleasant style, and to not get cocky or argumentative." A jury, in short, demands not only credibility but likability.

When the latter ingredient is absent, both attorneys agree, the results can be unfortunate.

"Style is probably 50 percent of getting your argument across," Baron said. "The best cases on paper don't mean a thing if a witness is arrogant or indifferent. Juries will use those negative characteristics to sink the best case in the world."

"Arrogant witnesses torpedo

the case, even when saying things [that are] perfectly plausible and defensible," Waller added.

Ultimately, attorneys maintain that physicians who underestimate the importance of their role on the witness stand during a malpractice trial can critically undermine their own defense. Instead of relying solely on professional expertise and experience, what's required is understanding and applying some fundamental points of positive human communication. Eye contact, humility and politeness won't alone ensure a victory, but they'll certainly help physicians make the best stand. ■

ISMIE slates loss prevention seminar

ISMIE will sponsor a seminar on Loss Prevention Strategies for Physicians in several locations around the state in 1999. Presented by practicing physicians and a defense attorney, the program will teach participants to recognize nonclinical factors that can contribute to a patient's decision to file suit, implement strategies to reduce liability and enhance defense, communicate more effectively with patients and improve record-keeping practices.

The seminar also will help participants earn CME credit required for license renewal. The Illinois State Medical Society designates this activity for a maximum of up to three hours of AMA/PRA Category 1 credit.

The schedule is as follows: 9 a.m.- noon, March 27, Oak Brook Hills Resort; 8:30-11:30 a.m., April 15, Jumer Chateau, Bloomington; 8:30-11:30 a.m., May 6, Joliet Holiday Inn Express; and 9 a.m.-noon, June 9, at ISMS offices, Chicago. To register, call (800) 782-4767, Ext. 1327.

MALPRACTICE ROUNDUP

Jury finds biopsy performed within standard of care

In a case argued in July before the California Superior Court, the jury found that the defendant's biopsy of the plaintiff's leg tumor was within the standard of care (Cunningham vs. UCSD Medical Center/Regents of the University of California).

As reported in the September issue of Medical Malpractice Law & Strategy, the plaintiff saw the defendant orthopedic surgeon for a biopsy of a tumor on her femur, which had been diagnosed by a pathologist as benign. She was given postoperative instructions on the use of crutches and not

putting weight on her leg. However, shortly afterward, the plaintiff sustained a fracture at the biopsy site. She alleged that the defendant's treatment was negligent, and that he had failed to inform her of all the risks of the treatment and of possible alternatives. The defendant contended that all the treatment provided was within the standard of care, that he had informed the plaintiff of all the risks of the procedure, and that they were not the proximate causes of her injury.

The jury agreed, returning a verdict in favor of the defendant.

Physician Strength

*Flexibility
collective
give physicians
in many
many*

BY JAN

Just last year, three independent practice associations merged into a single entity called the Chicago Area Physicians Association. It didn't take long for the newly formed group to realize that many can mean mighty. When a managed care company told the 140-physician group it planned to drastically slash its rates, CAPA flexed its market muscles right back.

"We threatened as a group to walk away from the contract," said James Downey, MD, CAPA's president. "Guess what? They backed down. They didn't want to give up our physicians, because our physicians are sought after by patients."

Without strength in numbers, physicians negotiating with an insurance company can feel as though they are talking to a brick wall. Physicians ask for better rates, but are crippled by the realization that their practices can't afford to lose the insurer's enrollees. Yet in accepting the company demands in order to avoid a short-term financial crisis, physicians often inch closer to long-term economic disaster.

However, physicians can weaken insurers' negotiating clout. Those who've joined forces by merging IPAs or adding physicians to their practices say they benefit from the power their bolstered numbers deliver in today's fiercely competitive market. Like CAPA, group participants report they've staved off rate reductions, cut administrative costs, improved information technology and regained control of their patients' care. Another example of a group effort making an impact is the more than 400 physicians in Dallas who recently terminated their contracts with Aetna Inc.'s health maintenance organization.

The "strength in numbers" tactic is certainly not new. Physicians actually have borrowed a page from the insurance industry, which has undergone a series of mergers as companies seek greater market leverage. Take the failed merger between United HealthCare of Illinois Inc. and Humana Inc., the state's second and third largest insurers, as an example. If it had succeeded, the merged entity would have controlled about 90 percent of the Chicago area's Medicare HMO market and 70 percent of its Medicaid HMO market.

The deal would have tilted the balance against good medical care, said Ken Robbins, president of the Illinois Hospital and HealthSystems Association, which protested the merger to the federal government on antitrust grounds. "Patients would have had reduced choices and, quite frankly, providers such as hospitals and physicians would have had unequal bargaining power during negotiations."

Advocates say joining forces allows physicians to fight back in the effort to control patient care, and ensure patients get the care they need. As Dr. Downey put it, "The direction of medicine belongs in the hands of physicians and their patients — not in the hands of insurance companies, hospitals, health systems, Wall Street firms or physician practice management companies."

Managed care may work even better if organizations owned and operated by physicians take charge, suggested Jon Christofersen, MD, a member of Dreyer Medical Clinic's board of directors and president of the Kane County Medical Society. "Patients want to get good medicine at a reasonable price. And if it's well done, managed care can provide that. If it's not well done, it lines the pockets of businessmen, costs the patients more money and provides less care. It's bad for everybody except the insurance company."

Dreyer, an Aurora-based multispecialty group with about 100 physicians, is a physician-driven clinic that became part of the Advocate Health Care system in June 1996. Dr. Christofersen credits the group's strength for holding a hard line in rate negotiations. While it's not unusual for Chicago-area physicians to



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very positive trade-off." — Robert Parker, MD

Julia Anderson-Miller

accept contracts that pay 10 percent over Medicare rates, or even straight Medicare rates, "we have not accepted these rates and don't plan to in the near future," Dr. Christofersen said.

"Medicare rates are horrendous," he added. "Being in a large group with a very significant market share, we've been able to command somewhat higher rates that would have been much worse — and may even be worse — for solo practitioners."

Dreyer maintains quality care at the same time it keeps an eye on rates, explained Dr. Christofersen. He pointed out that the HMO owned by the group and sold in 1996 to Blue Cross and Blue Shield of Illinois was rated among the top in the state in patient satisfaction. "Physicians made decisions on patient care, and patients got the care they needed," Dr. Christofersen said.

More physicians are gravitating to group practices, said Robert Parker, MD, chief executive officer of the Urbana-based Carle Clinic Association, a multispecialty group with 300 physicians. Ten years ago most physicians fresh out of residency programs chose to establish their own independent practices instead of joining already established group practices, he said.

But that's changed as young physicians have come to realize and appreciate the advantages of large practices. "We have absolutely no problems on the recruitment end today," Dr. Parker said. "They call us."

However, some physicians may be reluctant to join large groups because they fear losing independence. Robert Hamilton, MD, one of two surgeons with the Alton Surgical Clinic Ltd., told how he enjoys working with a smaller group and the independence that comes with it.

Still, many physicians who have banded together say the advantages make the concept well worth exploring. "In becoming a part of a team, physicians may have to give up a tidbit of autonomy and independence in order to get, in return, a better position in the marketplace," Dr. Parker said. "There's no question in my mind that it's a very positive trade-off."

Another potential barrier physicians contemplating mergers must consider is antitrust law violation. The risk of catching the attention of antitrust authorities increases as physician groups grow in size and market strength, explained Richard Raskin, an attorney with Sidley & Austin in Chicago.

"What raises the flags is putting together a large percentage of physicians in a particular specialty," he said. For example, if the only two cardiology practices in a small town merge, the surviving entity will control the prices for a particular service, and other providers such as hospitals will not be able to bargain for cheaper rates.

"Frankly, most physician mergers in urban environments are not going to hit the [government's] radar screen," Raskin said, adding that this may change as large physician groups continue to merge. "It's a growing issue." Organized medicine is working on federal legislation to alleviate antitrust pressure on physicians.

To decide if merging practices is right for you, Raskin suggested physicians outline goals and analyze how a merger would help meet them. "Mergers are not a panacea for . . . falling revenues and increased competition," he said. "For some it may be a terrific solution. For others it may be a disaster. A lot depends on who you are merging with and what each side brings to the table."

Carle Clinic physician Arthur Traugott, MD, pointed out that times have changed in health care and physicians need to change with them. "The bargaining position of the traditional solo practitioner is weakening, opening the way for managed care entities and the government to be evermore directive of health care decisions," Dr. Traugott said. "To challenge these forces, physicians need to be organized themselves." ■

Election

(Continued from page 1)

"Those reforms finally restored some balance to the areas of product liability, medical malpractice and liability for local governance. And now, we're back to the drawing board and we have to do it all over again," Ryan said during the campaign.

In addition, Ryan has proposed a comprehensive health care plan that includes a patient bill of rights.

Ryan will have to work with a divided General Assembly, however. Democrats edged out Republicans to maintain con-

trol of the Illinois House, winning two seats to hold a 62-56 majority. Meanwhile, the GOP held on to its control over the Senate, picking up one seat to reach a 32-27 majority.

The Illinois Supreme Court's decision to strike down the 1995 tort reform law prompted ISMS, the Illinois Civil Justice League and other organizations to take a close look at the qualifications of judicial candidates. To meet that goal, the ICJL created an endorsement process and educated voters about its picks.

Only one of the candidates endorsed for the state's three open appellate court seats won. Democrat Michael Gallagher

received the nod for one of the two open appellate court seats in Cook County, while Republican John Madden lost his bid for the other. Republican Thomas Appleton, a candidate for a Downstate appellate court seat, also lost.

Three physicians had attempted to become members of the Illinois delegation to Congress, but they were unsuccessful despite running spirited races. William Price, MD, a Belleville orthopedic surgeon and a Republican, lost his bid to unseat Democratic incumbent U.S. Rep. Jerry Costello in the 12th Congressional District by a margin of 60 percent to 40 percent. In the 9th Congressional District,

Herbert Sohn, MD, a Chicago urologist, was defeated by state Rep. Jan Schakowsky (D-Evanston) in the race to replace retiring U.S. Rep. Sidney Yates. Robert Marshall, MD, of Burr Ridge, lost to Democratic incumbent U.S. Rep. William Lipinski in the 3rd Congressional District contest.

In other statewide races, state Sen. Peter Fitzgerald beat U.S. Sen. Carol Moseley-Braun to become the first GOP senator from Illinois in more than 20 years. Attorney General Jim Ryan and Treasurer Judy Baar Topinka, both Republicans, were re-elected to their second four-year terms. ■

SOME
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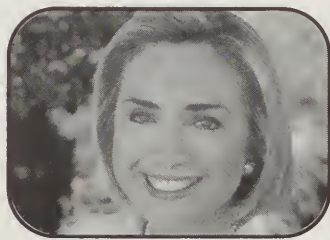
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IDPR DISCIPLINES

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June 1998

Jerrold Widran, Chicago – physician and surgeon license reprimanded and fined \$5,000 for allegedly not allowing a sufficient time interval between surgical procedures performed on his patient.

Thomas J. Woods, Chicago – physician and surgeon license suspended for six months followed by probation for five years after suffering a relapse from his treatment for alcoholism.

July 1998

Emmanuel Anawis, Chicago – physician and surgeon license placed on probation for three years and fined \$7,000 for providing medical services to entities which were precluded from engaging in the treatment of patients pursuant to Illinois law.

Robert S. Easton Jr., Metamora – physician and surgeon and controlled substance licenses revoked due to extensive history of cannabis dependence, rendering a drug screen which tested positive for cannabis and being terminated by his employer.

Divina L. Noble, Oak Brook – controlled substance license restored on probation for one year.

Alix Salomon, Crystal Lake – physician and surgeon license indefinitely suspended for ordering the admission of a patient to a hospital, and, as her attending physician, never saw the patient prior to her death the next day of septic shock and failure to report to the Department a settlement of a Cook County civil suit related to the matter.

Stephen Istvan Sipos, Waukegan – physician and surgeon license reprimanded for allegedly maintaining office records reflecting a lack of adequate charting and documentation in certain files.

Balkrushna Soni, Chicago – temporary physician and surgeon license reprimanded for adding to a patient's medical records after the patient complained about the manner in which he performed an examination.

Thomas Turcotte, Flossmoor – physician and surgeon license reprimanded for allegedly revealing confidential information regarding a patient's injury to the patient's employer.

Edgar Vargas, Chicago – physician and surgeon license reprimanded and fined \$500 for ordering a nerve conduction study on a patient which is not justified or supported by the medical records on the patient, and using a billing form that permitted the waiver of the balance due after the insurance payment.

August 1998

Celso Del Mundo, Chicago – physician and surgeon license placed on probation for one year for failing to maintain adequate medical records and documentation for a patient who experienced diabetic complications. The Department further asserts respondent's referral of this patient to a specialist may have been more appropriate at an earlier juncture in treatment.

Annette Hoffman, Chicago – physician and surgeon and controlled substance licenses summarily suspended pending proceedings before the Medical Disciplinary Board due to allegations she is impaired, self-prescribed drugs, and was dismissed from a rehabilitation program due to a relapse in substance abuse treatment, and failed to keep appropriate records for controlled substances in her office.

M. Kim Rodine, Decatur – controlled substance license restored to indefinite probation.

James H. Seubold, Aurora – controlled substance license restored on probation for two years.

Nick Vlachos, Bloomington – physician and surgeon license placed on probation for two years for engaging in unethical conduct by entering into a personal relationship with a patient.

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Andrew Corrigan Halpern

CARLA NOLAN, ISMS production/design manager for Illinois Medicine, was recently honored with the Society's quarterly employee recognition award. Her nominator described Nolan as determined and committed to producing the best-looking publication possible. A 15-year veteran of the Society, Nolan was part of the team that created Illinois Medicine in 1989.

Congress

(Continued from page 1)

participated in an AMA-organized lobbying effort in Washington, D.C., in July. They met with Illinois lawmakers to educate them about which reforms are needed in a final bill.

Both Democratic and Republican leaders generally agreed that a meaningful patient rights bill must include these key elements: full information disclosure, a right to appeal denial of care, a prudent layperson definition of emergency care and a ban on gag policies. However, they differed on the specifics of each reform.

A fifth reform – health plan accountability – became the chief obstacle during negotiations. It required eliminating an exemption from liability under state medical malpractice laws that many health plans now have through the Employee Retirement Income Security Act of 1974.

House Republicans, led by their point man on health care U.S. Rep. J. Dennis Hastert (R-Ill.), argued that ERISA reform would only pad the pockets of trial lawyers instead of solving patients' problems with managed care.

The GOP favored holding ERISA plans accountable using an independent appeal process that would allow patients to challenge plans' decisions to deny treatment.

Eliminating the ERISA protection, however, would give injured patients a legal remedy to pursue poor health care decisions made by insurers, supporters argued.

"It's time health insurers lived up to the same standards of consumer protection the law provides for virtually every other industry in the nation," Dr. Geline explained.

A GOP-backed bill passed the House with a narrow majority in August without the backing of the AMA, which noted that the measure didn't erase the ERISA exemption.

The AMA threw its weight behind a proposal sponsored by U.S. Reps. Greg Ganske (R-Iowa) and John Dingell (D-Mich.) in the House and Sen. Thomas Daschle (D-S.D.) in the Senate. This bill failed in the House.

Although the patient rights fight moved to the Senate, lawmakers had already become engulfed in other more pressing matters, such as the presidential scandal. On Oct. 9, with Congress preparing to finalize the budget and go home, senators voted not to address a patient rights bill this year.

Some argued that Congress' failure will only increase patients' suffering. "Over the past year we have heard story after story of abuses that should have been addressed," Daschle said. ■

Infectious diseases

(Continued from page 1)

cians' prescribing antibiotics only when necessary and educating patients about their appropriate use.

Other factors include changes in food processing and distribution, which are causing more multistate outbreaks of food-borne illness.

The purpose of the summit was to provide a forum for the public health and medical communities to address the challenges of these diseases and promote cooperative solutions. Several agencies are working to bring these concerns to

the forefront, including the U.S. Centers for Disease Control.

The CDC recently updated a 1994 plan to combat today's infectious diseases and prevent those of tomorrow. Several recent health events were behind the CDC's decision to revise its strategy. Among them was a new and virulent strain of influenza that, although it had never before infected humans, began to kill previously healthy persons in Hong Kong in 1997. The plan aims to build a stronger, more flexible U.S. public health system that is well-prepared to respond to known disease problems, as well as to address the unexpected, whether it be an

influenza pandemic, a disease caused by an unknown organism, or a bioterrorist attack.

Physicians play an integral role in detection, control and prevention of infectious diseases, particularly through reporting to local county health departments when patients are diagnosed with a reportable disease or condition, Dr. Bornstein said. Diligent reporting of infectious diseases helps the IDPH monitor incidences more closely, identify increases and respond more quickly, she added.

There are 58 communicable diseases and conditions required by the state to be reported to local health authorities. ■

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Court rulings

(Continued from page 1)

tracting AIDS from the cut and for her husband's fear of contracting it through sexual contact with her.

A judge found against the plaintiffs, saying a claim for fear of contracting AIDS requires actual exposure to HIV through an exchange of bodily fluids and a likelihood of developing AIDS in the future. An appellate court affirmed the judgment, but could not agree on a standard for evaluating the plaintiffs' claims for fear of contracting AIDS.

In the case involving six dental

patients, the trial judge dismissed the plaintiffs' complaints, stating they failed to allege sufficient facts to demonstrate a substantial risk of HIV infection. None of the plaintiffs has ever tested positive. The appellate court affirmed.

In its decision, Morse said, the high court affirmed the appellate courts' rulings in both cases. Justice Benjamin Miller wrote that, "without proof of actual exposure to HIV, a claim for fear of contracting AIDS is too speculative to be legally cognizable." Citing a previous decision, Miller added, "It is unreasonable for a person to fear infection when that person has not been

exposed to a disease."

However, the court made it clear that when an individual proves he or she was actually exposed to the virus, "a genuine fear of contracting AIDS may exist," whether or not the claimant later tests positive for HIV. In fact, Miller continued, an individual need not even "demonstrate a likelihood of developing AIDS in the future in order to state a claim for fear of contracting AIDS."

However, the court limited any "window of anxiety" by stating that, "once in receipt of reliable HIV-negative test results, an individual's fear of

contracting AIDS would no longer be reasonable."

Physicians entitled to damages arising from nonpayment of liens

In another notable ruling, the court weighed in on physician liens. At the heart of its decision was the Physicians Lien Act, intended to ensure that physicians be paid for services they provide in emergency situations.

At issue was a plaintiff physician who treated an auto accident victim and filed a lien with the patient's attorney for services rendered. The attorney never reimbursed the physician despite receiving two checks from the patient's insurer. Arguing at trial that formal aspects of the lien — addresses, dates and liable parties — weren't properly listed, the defendant insisted it be defeated. The court, however, ruled the lien valid, and a jury awarded both compensatory and punitive damages. Upon appeal, the punitive damages were reversed by the appellate court, which said such damages are unavailable under a breach of contract claim.

In a decision written by Justice James Heiple, the Supreme Court agreed the lien was valid, despite its shortcomings, opting not to choose "form over substance." Heiple rejected the idea this was a breach of contract claim and said the facts proved conversion instead, a claim under which punitive damages can be awarded. On this count, the Supreme Court reversed the appellate court, reinstating punitive damages.

"The court now has said, 'We take physician liens very seriously,'" Morse stated. The ruling is good for physicians, he concluded. "Too frequently, physician liens are ignored. This important ruling should give physicians the confidence to file liens and to follow up on them." ■



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John McNulty

ISMS President Richard Geline, MD, offers input during a discussion on protecting patients' rights in the health care market that was part of a recent series sponsored by the Chicago Health Policy Research Council. The event was held at the University of Chicago Downtown Gleacher Center. John Crosby, DO, executive director of the American Osteopathic Association, was moderator.

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PAGE 6

Illinois Medicine

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The truth
about
patient
rights

PAGE 7

Society debuts 1998 HMO guide

TOOL: Physicians, patients make better choices armed with a health plan's financial data. BY JANE ZENTMYER

Patients in search of an HMO, and physicians leery of contracting with one, may first want to get a better picture of an organization's financial health by reading ISMS' 1998 Patients' Guide to Illinois

Health Maintenance Organizations. The publication presents data on the 44 HMOs operating in Illinois in 1997.

"The guide can help patients select a plan that will give them the best deal for their dollar,"

ISMS President Richard Geline, MD, said. "It gives employers an overall picture of a plan's availability of services, and can give physicians an idea of an HMO's financial shape."

Readers, for example, can compare the percentages of income spent on medical care, which varied greatly from one HMO to another. Moline-based John Deere Family Healthplan Inc. - at 122.38 percent - spent a higher percentage of income on medical care than any other Illinois HMO, the guide reports. Chicago-based Community Health Choice of Illinois spent the least, with only 9.08 percent of its income allocated for patients' medical care. The average amount of income HMOs spent on medical care

(Continued on page 2)

Who spent the most/least on medical care?*

Most spent	% of income
John Deere Family Healthplan.....	122.38%
Oxford Health Plans (IL).....	116.32%
Maxicare Health Plans of the Midwest.....	111.07%
Country Medical Plans.....	104.64%
Benchmark Health Insurance.....	102.76%
Least spent	% of income
Harmony Health Plan of Illinois.....	78.28%
Health Alliance - Midwest (Carle).....	77.50%
Community Health Plan of Sarah Bush Lincoln.....	75.81%
Healthlink HMO.....	51.38%
Community Health Choice of Illinois.....	9.08%

*The ISMS 1998 Patients' Guide to Illinois Health Maintenance Organizations ranks in decreasing order the percentage of income spent on medical care by the 44 HMOs operating in Illinois in 1997.

ISMS online New Web site unveiled

BY PAULA KRAPP

ISMS has launched a new site on the World Wide Web that offers members and the public 24-hour access to health care news, Society activities and resources, and additional Web information.

"ISMS online creates a communications tool in step with a computer age that demands quick access to information," said ISMS President Richard Geline, MD. This new online presence gives ISMS a World

Wide Web identity in the eyes of the public, the media and members, he said.

The advocacy section, for example, details ISMS activity in the federal debate on patient rights and insurance contract reform, with instructions on how members can get involved in influencing legislators.

The new site (www.isms.org) also offers the capability to quickly and easily contact ISMS with a question or request.

There is a means to send letters electronically to the editor of Illinois Medicine and to request ISMS membership applications.

In addition, the site links to Illinois medical societies, medical schools, government agencies and worthwhile medical Web sites. A CME section provides licensure requirements, a list of ISMS accredited institutions/organizations and educational opportunities.

Of special interest to the public, the site contains health

(Continued on page 10)

INSIDE

Physicians' unions
What's getting
in the way?

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John McNulty

"The AMA has to turn itself around," E. Ratcliffe Anderson Jr., MD, the American Medical Association's executive vice president, told ISMS members in September. The pending vote on a plan to revamp the association should foretell if his statement will come true.

AMA weighs plan to clean house

OVERHAUL: Scathing report points to serious flaws in decision-making process.

BY JANE ZENTMYER

As part of the American Medical Association's efforts to polish its tarnished image, its House of Delegates will debate - and ultimately vote - on a plan to revamp the AMA's inner workings at its December Interim Meeting in Honolulu.

The proposal follows a yearlong effort of the Ad Hoc Committee on Structure, Governance and Operations to review the association, top to bottom. The committee was created by delegates after the much-criticized Sunbeam debacle raised serious questions

about the AMA's direction and performance. The committee relied on an independent management audit conducted by Booz-Allen & Hamilton Inc., a Virginia-based consulting firm, to develop more than 30 house-cleaning recommendations.

"The committee's report will be welcomed by delegates," said Edward Fesco, MD, chairman of Illinois' AMA delegation. "Once the report is digested by the delegates and it comes back to the states, counties and specialty societies, I think doctors will feel better about the AMA because it's facing up to the realities of some needed changes."

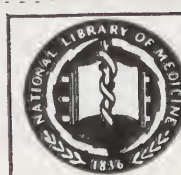
The committee's 28-page report dishes out advice to all levels of the organization -

(Continued on page 8)

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HMO guide

(Continued from page 1)

remained at 87.7 percent in 1997, compared with 1996.

New features have been added to the guide's third annual edition to improve its readability and usefulness. The guide now ranks HMOs in different categories, such as the amount of money spent on medical care and administrative expenses. As a result, patients, physicians and business owners can use the rankings to determine how a particular HMO stacks up against its peers.

The updated guide also includes each HMO's accreditation status with the National Committee for Quality Assurance. "Right now, NCQA accreditation is one of the only objective benchmarks available to indicate HMO quality," Dr. Geline said. "If a plan has not made the commitment to become accredited, patients could reasonably ask the plan, 'Why not?'"

HMO profiles were compiled using information extracted from annual reports the plans must file with the Illinois Department of Insurance. Each HMO received an opportunity to review the information included in the guide, and their comments have been included in the report. Richard Bohn, president of OSF Health Plans, in Peoria, commented that, "We believe that the financial statements filed with the DOI present, at best, only a partial picture of any one HMO's current situation."

Share your HMO experiences

What do you think of the HMOs you work with? Physicians will have a chance to give thumbs up or thumbs down to the HMOs in their lives by participating in an ISMS survey to be mailed soon.

The HMO Physician Satisfaction Survey is being conducted to collect

information from physicians about their experiences with some of the state's largest health maintenance organizations.

The results will be used to help shape ISMS' legislative efforts in Springfield and to help the Society improve its advocacy efforts for physi-

cians in the managed care marketplace.

The survey includes general questions on contracting issues that physicians face with HMOs. It also asks physicians if they would recommend a particular HMO to a colleague or if they would enroll as a patient in a particular HMO.

Please fill out the survey and return it as soon as possible. Illinois Medicine will publish the results when they become available.

The guide is intended as a starting point, according to Dr. Geline, who encouraged patients and others to contact their HMOs if they desire additional information. For example, patients may want to ask their HMO for data on patient satisfaction levels, health outcomes and preventive care, such as child immunization rates.

Some HMOs praised the guide for its usefulness. "I would like to compliment you on the straightforward instructions for review and on the easily understood descriptions of the data elements," said Margaret Woo, contract analysis manager for Humana Inc. in Chicago.

More than 2.3 million Illinoisans counted on HMOs for their health care in 1997 - a 6 percent increase over 1996. Patients paid an average \$1,801 premium in 1997 for their HMO's services, a 6.3 percent increase over 1996. Premiums ranged from a low of \$373 annually for the St. Louis-based Health-

link HMO to a high of \$3,373 for the Aurora-based Dreyer Health Plans.

Patient mix can impact premium highs and lows. A high Medicare enroll-

ment, for example, is a factor in the premiums at Dreyer, a plan that exclusively enrolls high-cost Medicare patients.

In 1997, 25 HMOs experienced losses while 19 HMOs saw their profits or surpluses rise. The range varied from a loss of over 1,000 percent to a profit margin of 15.8 percent. HMOs

that lost money may have done so because they were new or expanding, or because they were having financial difficulty. The average percent for all HMOs of income spent on administrative costs remained stable at almost 14 percent between 1996 and 1997. Newer HMOs typically have higher administrative expenses, which may be attributed in part to start-up costs.

HMO Illinois began operating in the mid-1970s, and its 1997 administrative costs were the lowest in the state at about 5 cents of every dollar of income. On the other hand, Community Health Choice of Illinois began operating just last year and spent more than \$13 on administrative costs for every dollar it collected. The guide is available without charge by writing to ISMS, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602; or by calling (312) 782-1654 or (800) 782-ISMS. The complete guide can be downloaded from the revamped ISMS Web site at www.isms.org.

"The guide can help patients select a plan that will give them the best deal for their dollar."

- Dr. Richard Geline

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Who spent the least/most on administration?*

Least spent	% of income
HMO Illinois.....	4.83%
Union Health Service.....	6.40%
Dreyer Health Plans.....	8.48%
BCI HMO.....	8.59%
Health Alliance Medical Plans (Carle).....	8.96%
Most spent	% of income
One Health Plan of Illinois.....	37.28%
Harmony Health Plan of Illinois.....	46.39%
Unity HMO.....	65.02%
Americaid Illinois.....	84.89%
Community Health Choice of Illinois.....	1304.40%

* The ISMS 1998 Patients' Guide to Illinois Health Maintenance Organizations ranks in increasing order the percentage of income spent on administration by the 44 HMOs operating in Illinois in 1997.

Health research takes starring role in Glenn's return to space

In addition to being the only near-octogenarian to orbit the earth, John Glenn was, throughout his historic mission, America's loftiest medical experimentation subject.

Glenn, who almost four decades ago was the first American to orbit the earth as the sole astronaut in Mercury space capsule Friendship Seven, recently returned to space as a payload specialist on the space shuttle Discovery. On the fifth day of the mission, Glenn became the subject of advanced experiments

that may ultimately impact diabetes control and help develop technologies for fighting colon cancer.

The near-weightlessness of space - a condition astronauts term "microgravity" - provides a unique environment for analyzing the effects of drug interactions in the body, as well as the body's own tolerances for various treatments. Overall, more than 54 experiments were orchestrated during Discovery's mission to take advantage of the microgravity conditions.

1999 Annual Meeting and resolution deadline dates

Mark your 1999 calendars now for some important dates: The ISMS House of Delegates Annual Meeting will be held April 23-25 at the Oak Brook Hills Resort, 3500 Midwest Rd., Oak Brook.

County medical societies should submit a list of delegates and alternates to

Supreme Court hears arguments in suicide case

Plaintiff and defense attorneys recently appeared before the Illinois Supreme Court to argue whether physicians can use a legal theory called "contributory negligence" when defending themselves from a medical malpractice lawsuit stemming from a patient's suicide.

This legal theory says patients can be responsible for part or all of their injuries. An appellate court ruling issued late last year in the Hobart vs. Shin case said, in effect, that "mentally ill" individuals cannot be responsible for their conduct, and physicians are either 100 percent responsible for a patient's suicide or completely not at fault.

Hobart vs. Shin stems from the suicide of a patient who overdosed on an antidepressant prescribed to her by both her family physician and psychiatrist. The patient's family filed a suit alleging that the failure of her family physician to inform the psychiatrist that he wrote the prescription ultimately gave the patient access to enough antidepressant to commit suicide.

ISMS, the Illinois Psychiatric Society and the Alliance for the Mentally Ill of Greater Chicago submitted a joint amicus curiae brief that challenges the decision based on Hobart vs. Shin, and defense attorneys relied heavily on that brief when making their case to Supreme Court justices in October.

The defense argued that treatment for mental illness doesn't automatically mean the patient is incapable of making decisions. The ISMS brief points out that treatment for mental illness often involves promoting the patient's responsibility for his or her actions, and the court's decision could undercut physicians' ability to care for patients.

The plaintiffs argued, however, that it was arrogance on the part of the medical community to believe that anyone who commits suicide is rational. They also argued that the physicians should have had a heightened awareness of and responsibility for the patient's actions because she was being treated for depression. A high-court ruling is expected soon. ■

ISMS headquarters by Friday, Jan. 29. All delegates and alternates will be notified of the meeting through an official meeting call.

Resolutions must be received at ISMS headquarters by 4:45 p.m., Wednesday, March 24; a March 24 postmark is not sufficient.

After that date, resolutions will be considered late and will be reviewed by the Committee on Rules and Order of Business to determine whether the House

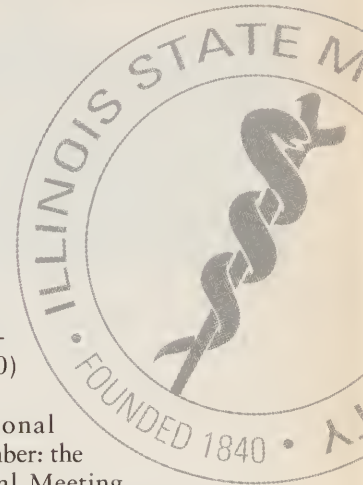
should consider them. Only delegates and other voting members of the House of Delegates may submit resolutions.

Resolutions should be addressed to: John Schneider, MD, Speaker of the House of Delegates, Illinois State Medical Society, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602. They can also be e-mailed to HOD@isms.org.

Informational materials and meeting packets for the ISMS Annual Meeting will be mailed to House members and

county medical societies. For more information, call (312) 782-1654 or (800) 782-ISMS.

An additional date to remember: the ISMIE Annual Meeting has been scheduled for April 21, also at the Oak Brook Hills Resort. ■



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REPORT for Illinois Physicians

CARE-VALUE PATHWAY: Acute Congestive Heart Failure

Presented below is another in a series of Care-Value Pathways (Refer to 4/17/98 "Report" for initial Pathway description) developed by Blue Cross Blue Shield of Illinois. This Pathway addresses Acute Congestive Heart Failure (CHF).

As of 10/98

Key Opportunities

- Vigorous workup and diuresis.
- Early referral of patients experiencing a second CHF episode to re-admission prevention initiatives.

Admission Criteria:

Patients with dyspnea on exertion and pedal edema with rales or other major indicators of fluid retention may require admission.

Note: Some patients can be discharged to close home health or office follow-up if symptoms greatly respond to initial IV diuretic treatment provided in the ER or Urgent Care Center.

Optimal length of Stay:

Two to three days.

Day 1

Patient receives aggressive IV diuresis and appropriate tests to rule out acute treatable etiologies. Patients previously admitted for similar episodes are referred to case management or home health.

Day 2/Subsequent Day

Vigorous IV diuresis continues with switch to PO diuresis targeted for morning of Day 2 or Day 3. Use of ACE inhibitor considered unless contraindicated. Attention is paid to:

- Patient's targeted baseline weight
- Patient's renal function and electrolytes
- Dietician referral for reinforcement of <2 gram sodium diet.

Discharge Criteria

Acute MI has been ruled out and patient can both ambulate to bathroom without supplemental oxygen and demonstrate an increased understanding of the medication and diet regimen.

Case Management/Disease Management

Home health agency follow-up all Class III and IV patients twice weekly to evaluate:

- Weight
- Compliance with diet and medications
- Level of self-management skills

Case management (or disease management vendor where contracted) will also provide healthy life style information and when prescribed by the physician, encourage compliance with a moderate exercise program.

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EDITORIAL

Staying in touch just got easier

As proudly announced on Illinois Medicine's front page this issue, ISMS launched a new World Wide Web site – a 24-hours-a-day, 7-days-a-week electronic billboard of Society activities and resources.

ISMS Online opens a whole new avenue for members and the public to access ISMS information and resources. Access the site and you will find a calendar of Society council, committee and board meetings; legislative news; and links to member resources. Click on the words "A Personal Decision" to order copies of the newly revised ISMS booklet on end-of-life decisions.

The timing of this site is ideal given the tremendous growth of Internet usage by physicians, as well as the public in general. An AMA study taken one year ago found 20 percent of physicians used the Internet, but predicted that figure would jump to 32 percent just six months later.

But staying in touch is a two-way street. The new site not only reaches out, it also makes it much easier to reach right back. From the home page, for example, users can select "Contact ISMS" to jump to a directory – with e-mail hot links – of staff specialists in every ISMS division, including education and licensing renewal,

government affairs, health care finance and legal resources.

Another section provides an ISMS leadership list that makes it easy to type a message to the Society's president, president-elect and chairman. The Society's goal is to respond to each e-mail within two business days.

Now that communication is a bit easier, there is less justification for an empty mailbox on the receiving side. Granted, physicians run at a frenetic pace. But judging by the response to the many heated issues facing the health care industry, physician interest in voicing their views on important issues can only be called abysmal. In the past six months, despite being packed with many controversial issues – AMA deunification debate, patient rights battles, government regulation fuss, etc. – there has been only a handful of letters sent to the editor of this publication. Note that the new Web site has an instant e-mail route for composing and sending letters to Illinois Medicine.

Take a few moments to become acquainted with all aspects of ISMS Online. Bookmark it or add it to your list of favorite places. Test it out by e-mailing a comment, question or letter. Agree with ISMS, disagree, tell the Society what you need. We look forward to hearing from you.

PRESIDENT'S LETTER

Can physicians unionize if they want to?

Richard A. Geline, MD



Physicians need sweeping legal protection to act collectively in bargaining with payers.

In our profoundly changing health care environment, collective action – unionization – looms as an option for physicians. As I discussed in my previous President's Letter, even if physicians get past the ethical quandary posed by unions, a more tangible obstacle immediately arises.

That obstacle is antitrust law. The Sherman Antitrust Act of 1890 broadly prohibits contracts, combinations and conspiracies in restraint of trade. Physicians who practice independently, but join labor unions to collectively bargain with payers, run a great liability risk of being charged with price fixing, which carries heavy penalties.

How can collective action be illegal when the goal of physicians is merely to level a playing field where managed care organizations are stronger, seem to hold all the high cards, and negotiate with a "take it or leave it" attitude?

Physicians must understand that antitrust laws were not written to level the playing field for sellers of goods and services; they are first and foremost consumer protection statutes. With regard to the union movement, antitrust laws represent a fundamentally opposing culture.

Antitrust law holds that collective action by sellers of goods and services is a bad thing because it injures consumers; the union movement holds that collective action by sellers (in this case, the physician) of goods and services is a good thing because it allows them to take back some bargaining power from buyers (in this case, the managed care organization). In the circumstances relating to physicians, the basic thing that unions exist to accomplish is the very same basic thing that antitrust laws exist to prevent.

Stepping outside defined boundaries carries substantial risk. The federal authorities view current law as good public policy and enforce it aggressively. Penalties for violations are severe, including

payment of treble damages as well as attorneys' fees, not to mention possible jail sentences.

Physicians practicing independently can find relief through formation of physician networks and joint ventures. When physicians form a network as a legitimate joint venture, and integrate their activities in the venture by sharing financial risk or by achieving clinical integration likely to produce substantial efficiencies, the collective activity, while reasonably necessary to the joint venture, is subject to antitrust analysis under the more lenient "rule of reason" rather than the stricter "per se" rule, according to an AMA report.

Nonetheless, it may be necessary – and perhaps difficult – to convince a payer, antitrust prosecutor, judge or jury that the arrangement will benefit consumers rather than provide the mere (and illegal) massing of bargaining power that will benefit physicians to the detriment of consumers.

For employed physicians, the problem is neither as gloomy nor as complex. Their union activity is clearly protected under well-established provisions in federal antitrust laws as well as federal labor laws.

The law views employed physicians no differently than it does workers in other professions and industries. Physicians employed by a single staff-model HMO or hospital system are perfectly free to unionize and to have the union represent them in negotiating the terms of their employment relationship.

All the legal points discussed in this most abbreviated way are derived from current law as enacted by Congress and interpreted by the courts over the years. Just as Congress has created the current legal landscape, it can alter it by enacting new laws. Physicians need sweeping legal protection to act collectively in bargaining with payers.

That sounds like a plan for organized medicine at all levels.

ISMS on record

ISMS president addresses managed care in county

Ottawa Daily Times Oct. 7, 1998

"Illinois, and the nation, are closer than ever to gaining comprehensive laws protecting the patient-doctor relationship; and grassroots contact from individual patients can spur lawmakers to action," said Illinois State Medical Society President Richard A. Geline, MD, as he addressed doctors at a meeting of the Williamson County Medical Society in Herrin [Ill.] . . . "We need managed care reform. We must stop interference in the doctor-patient relationship by nonmedical decision makers concerned only with the cost of medical care and not the quality. The weeks and months ahead offer an unprecedented opportunity to get that message across to those in a position to do something about it," said Dr. Geline." ■

Collecting HIV data

Bartlett Daily Herald Oct. 26, 1998
Letter to the editor from Dr. Geline

"The Illinois State Medical Society strongly supports name reporting [of HIV-infected patients] because it enables the fastest and most accurate tracing and notification of people at risk of infection, getting those in need into counseling and treatment more quickly. However, it has drawn intense emotional opposition based on a perception that patient confidentiality could be harmed – even though Illinois' record in protecting the confidentiality of AIDS patients, whose names have been collected for years, is unblemished. . . . While we've made great strides in treating HIV, prevention remains the only cure for the virus and the disease it causes." ■

ISMS president urges action on patients' rights legislation

Effingham Daily News Oct. 23, 1998

"Illinois State Medical Society President Richard A. Geline, MD, traveled . . . to Effingham to speak to the Effingham County Medical Society. Geline's seventh annual visit was part of a statewide tour in which he speaks to various county medical societies. During his visit, he emphasized a need for physicians to be involved with the political process. . . . This recommendation comes at a time when both the Illinois General Assembly and U.S. Congress have been flooded with managed care reform bills." ■

Lousy track record

Chicago Sun-Times Sept. 13, 1998
Letter to the editor from Dr. Geline

"The Sun-Times [Sept. 7] reports that three out of four people with complaints against their HMOs were vindicated by the Illinois Insurance Department last year. That's a damning indictment of the decisions HMOs make regarding high-quality patient care and further proof we need strong managed care legislation emphasizing patients rights in our state. . . . [We] need managed care reform that does more than fix bad decisions after the fact. To finally stop needless delays and suffering, we need to protect patients from bad decisions in the first place." ■

Recent articles in Illinois newspapers show that ISMS is carrying the voice of physicians across the state. Through editorials, letters and interviews, ISMS President Richard Geline, MD, is showcasing the Society's stand. Here are some clips:

More options for doctors are backed

Decatur Herald & Review Oct. 28, 1998

"Decisions about health should be made in an examination room or in a hospital, not in the offices of managed care bureaucrats. That's the message Illinois State Medical Society President Richard Geline brought to Decatur . . . as he addressed members of the Macon County Medical Society . . . 'Managed care is managed money,' Geline said. 'The problem is that medicine doesn't fit too well into the predetermined formulas that they set up.'" ■

ISMS president urges passage of patients' rights legislation

Paris Beacon-News Oct. 6, 1998

"Physicians must remain active as an 'advocate for the patient,' and not become mired in the debate over the allocation of health resources. This was the message delivered . . . by the president of the Illinois State Medical Society as he met with members of the Edgar County Medical Society at Paris Community Hospital." ■

State medical society pushes patients' rights

Freeport Journal-Standard Sept. 26, 1998

"Physicians, not health plan administrators, should control patient care," said Dr. Richard A. Geline, president of the Illinois State Medical Society. . . . "It's time to bring decision-making back to physicians and restore the physician-patient relationship. Basic things such as making sure patients have their choice of physician are what we are addressing at the state level." ■

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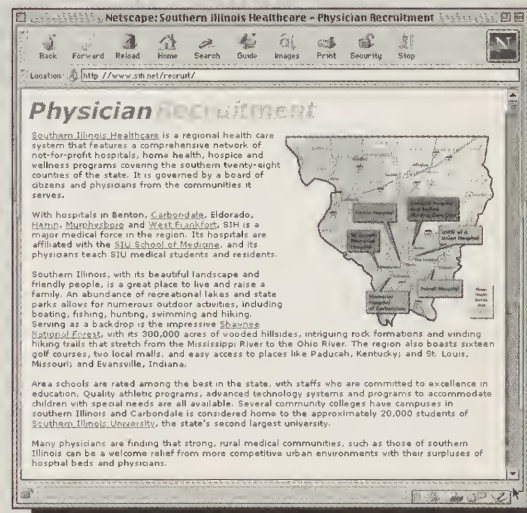
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ISMIE Update

Outpatient surgery: Weighing the risks

BY NINA BERNARDI

Not long ago, the prospect of performing a gallbladder removal and then sending the patient home several hours later was about as remote as performing same-day kidney transplants.

Nonetheless, laparoscopic cholecystectomies are now on a growing list of procedures being performed in an outpatient setting. The trend toward outpatient procedures, in hospitals as well as freestanding centers, has created considerable cost and convenience benefits for patients and the companies who insure them.

For physicians, however, it can be a mixed bag. As pressure mounts to perform more and more procedures on an outpatient basis, the legal risks connected with issues including premature discharge could also be mounting, said Rudy Schade, a senior partner with the law firm of Cassidy, Schade & Gloor in Chicago. If a patient is injured because an outpatient surgery should have been performed as an inpatient one, "ultimately, it is the physician who will be sued," he said.

INPATIENT VS. OUTPATIENT? DRAWING THE LINE

Ambulatory surgeries comprised 60 percent of the total surgical procedures performed at Illinois community hospitals in 1996, according to the Illinois Hospital and HealthSystems Association. The trend is in part being driven by technology advancements, said Richard Sperling, MD, plastic surgeon and president of the medical staff at Rush North Shore Medical Center in Skokie. "Before, there was really no way you could do [many procedures as outpatient]," he said.

Cost savings for patients and for managed care companies have also ushered in and sustained the trend. The hospi-

tal charge for an outpatient rhinoplasty is about \$800, compared with about \$3,000 for the inpatient procedure, Dr. Sperling said. "Medical care is expensive. Patients realize if they can get procedures done safely as an outpatient, it's to their advantage."

But how do physicians draw the line when the insurance protocol says "outpatient" and their own judgment screams "inpatient?"

Attorney Peter Mone of the Chicago office of Baker & McKenzie offers this clear-cut rule to physicians. "For surgery that requires more than a local anesthetic, patients should be kept overnight to see how things develop," Mone said. "Don't get into the practice of conveyor line surgery. Anyone doing a lot of procedures in one day is begging for bad results."

The schedule connected with same-day surgery leaves less time for informed consent and proper follow-up, he added. Physicians who do same-day surgeries with a general anesthetic should explain the warning signs of complications to the patients, and thoroughly document those conversations, Mone said.

Physicians should also clearly document conversations with insurance companies, noting especially any disagreements in judgment.

John Kinzer, MD, an anesthesiologist and medical director of Golf Surgical Center in Des Plaines, said his center conducts a brief history and physical on each patient to determine his or her risks. If patients reveal warning signs, such as angina, uncontrolled high blood pressure or a tendency toward bleeding, Dr. Kinzer recommends they visit their physician for a "tuneup" to get their medical condition under control first.

Remembering the physician's primary role as the patient's advocate makes the outpatient vs. inpatient dilemma an easier call, said Irwin Benuck, MD, an Evanston pediatrician.

Dr. Benuck recalled a case where he hospitalized a child with cellulitis. A utilization review nurse called and told him he could have treated the child as an outpatient with antibiotics. He took a deep breath, explained the situation, and garnered approval for a two-day hospital stay for his patient, which was adequate.

In an ironic twist, Dr. Benuck said an insurance company penalized him for treating a baby with a kidney infection as an outpatient because the protocol dictated hospital care, even though he saved the insurance company thousands of dollars. That was not his motivation.

Dr. Benuck chose to treat the baby as an outpatient because he was confident, with the proper testing and treatment, the best place for the baby to recover was at home. He also chose outpatient care in this case because the family was well known to his practice and compliant. He has done more cases since the first without the red tape.

"The key determining factor is that I feel comfortable with this therapy," said Dr.



Jim Flynn

Benuck. "It's the exact same thing we're doing in the hospital. Legally, I'm at the same risk I would be with a hospitalization," he said, adding that patient safety should always be the overriding con-

cern in the outpatient vs. inpatient decision. "You can only be employed by one person and that's your patient. That way, you have no conflict of interest." ■

Nominations sought for ISMIE board

Election to be held at April 21 Annual Meeting

The Illinois State Medical Inter-Insurance Exchange will hold its upcoming Annual Meeting on April 21, 1999, at the Oak Brook Hills Resort in Oak Brook. At that time, ISMIE's Board of Governors will be elected. Board members will be elected by a majority vote of those members represented at the Annual Meeting in person or by proxy.

The Board of Governors has general supervision over ISMIE's finances and operations; it also establishes all policies governing the proper transaction and conduct of ISMIE business and affairs.

Exchange members interested in serving as a governor should provide a 150-word statement of interest along with a current curriculum vitae to Harold Jensen, MD, Chairman, Board of Governors, ISMIE, 20 N. Michigan Ave., Suite 700, Chicago, IL 60602.

Each candidacy must be seconded in writing by two other ISMIE policyholders. ISMIE members may second nominations for up to seven separate and individual candidates. All curricula vitae and written seconds must be received by the ISMIE office on or before Dec. 31, 1998.

Candidate submissions will be reviewed by the ISMIE Nominating Committee, which will then provide a recommended slate of nominees. Potential candidates not recommended by the committee will be so advised and can elect to be placed on the ballot as an independent.

The truth about patient rights

ISMS sets the record straight on
managed care reform misconceptions.

BY JANE ZENTMYER

LAWMAKERS CONVENED in Springfield last week to decide the fate of last session's bills vetoed by the governor. As a result, managed care reform might get another shot at passage. This spring the House and Senate each passed its own managed care reform bill, but the two chambers failed to reconcile the bills' differences by session's end.

ISMS launched an uphill battle for patient rights in 1996 when lawmakers began debating its Managed Care Patient Rights Act. A meaningful patient protection law, however, has been hampered by reform opponents from the business and insurance industries who have used their considerable clout to block the law's passage.

"We've fought hard to protect patients from the oppressive tactics of managed care companies but our adversaries have distorted and misin-

terpreted our positions," said ISMS President Richard Geline, MD. "ISMS and other supporters of managed care reform plan to continue a vigorous fight."

Most political analysts don't expect the reform issue to resurface until after the newly elected governor takes office next year. Many of the same reforms included in this year's bills are expected to become part of any future legislation.

As the debate continues, the negotiations will undoubtedly lead to further misconceptions about the impact of various reforms. ISMS wants to set the record straight. The table below identifies some of the common misconceptions spread by reform foes and explains the proposals shaped by the Society and other advocates fighting to protect patients from managed care abuses.

Myth: *Reform opponents have fed the following inaccurate predictions to the public about the impact of patient rights proposals.*

Accreditation:

- All independent physician associations and physician groups that conduct utilization review activities on a delegated basis must be accredited, at a cost of at least \$10,000, by the American Accreditation HealthCare Commission/URAC.

Primary care physicians' role:

- The proposal turns specialists into primary care physicians.
- "Health care plans must give primary care physician credentials to physicians who have no training in primary care," according to a legislative analysis from the Illinois Association of Health Maintenance Organizations. "If this measure becomes law, our public policy in Illinois would be that physicians not trained to do surgery cannot perform surgery, but physicians not trained to do primary care may do primary care."

Specialists' access:

- The contracting ability of IPAs and physician hospital organizations would be useless with the creation of a principal care provider.
- IPAs and PHOs "would effectively be unable to direct care to specialists affiliated with their organizations. As a result, IPAs and PHOs could be expected to face immense problems in continuing to contract successfully with HMOs," IAHMO reported in its Fall 1998 newsletter.

The cost of reforms:

- Reforms would substantially raise health care costs. Some business groups have estimated that managed care patient rights reforms would increase employer health care expenses by as much as 12 percent in 1 year.

Emergency care services:

- HMOs currently do not deny emergency room coverage so there is no need for legislation to address this issue.

Gag clauses:

- Health plans do not restrict physician/patient treatment discussions, reform opponents say. And attempts to eradicate gag clauses are too broad and may prevent health plans from imposing any restrictions on physicians.

Fact: *ISMS explains how reform proposals actually would affect patients and the health care industry.*

- No managed care entity or other insurer will be required to obtain URAC accreditation. Rather, anyone performing utilization review in Illinois would be required to use URAC standards.

- Under proposed reforms, patients must choose a primary care physician – trained in primary care – who will be responsible for coordinating their care, including all referrals, and who meet the requirement for being a PCP as defined by the plan.

Patients with a condition that requires ongoing care from a specialist can request a standing referral to a second physician called a "principal health care provider." The health plan defines the criteria and conditions patients must meet in order to obtain a standing referral. If the plan denies their referral request, patients can challenge the decision using an independent appeals process.

- Patients can choose any physician they want to be their principal care provider, but the selection must be coordinated between the two physicians.
- The proposal requires patients to choose a principal care physician who has a referral arrangement with their primary care physician or to change to a PCP who has a referral arrangement with the chosen principal care provider. In crafting this language, ISMS was responding to IPAs' request for language that keeps referral relationships within their existing structure.

- Business groups have never released the methodology they used to devise their cost estimates, or provided any credible backup for their projections.
- This July the Congressional Budget Office estimated that a federal patient rights bill, which includes many provisions included in Illinois proposals, would increase premiums by only 4 percent. This hike is a one-time increase – not an annual increase – and would be phased in over 10 years, according to the CBO.

- Many patients have been turned down for necessary emergency room coverage, which is why the Illinois proposals seek to ensure that HMOs provide coverage using the federal prudent layperson definition for ER treatment.

- The AMA has found numerous gag clauses and practices in contracts regularly offered by major managed care companies. Legislation is necessary to ensure that physicians are allowed to inform patients about their range of treatment options without fear of retaliation. For example, this addresses physician deselection for advocating for their patients.



AMA report

(Continued from page 1)

the AMA's board, presidents, committee members, delegates and staff. Many of its suggestions focus on the need to improve the AMA's communications ability both internally among staff, the board and committees, and externally with physician members.

To help reach grassroots physicians, the committee plan encourages delegates to recognize their responsibility to communicate with their constituents and to solicit their views on medical issues. A

comprehensive review of the AMA's communications processes, including its existing staff, publications and Web site, is recommended to identify areas that need improvement.

ISMS earlier this year called upon the AMA to open its board meetings as a way for the organization to connect with its physician members and to build trust. However, the 10-member committee rejected the open meeting idea in favor of proposing a self-evaluation program.

"The current lack of trust is a driving factor in the strong feelings among delegates that board meetings should be open and votes should be recorded," the

committee concluded in its report. "Instituting the self-evaluation program will help restore trust in the board while preserving efforts to encourage more deliberation among the trustees over critical and often divisive issues."

The self-evaluation program would assess the board's ability to meet specified annual goals, and it would ensure the board's performance fulfills the will of the House. The committee recommended recruiting outside help to design such a program and called for the House's involvement to ensure collaboration and agreement on the board's role and achievements.

AMA bylaw changes are needed to focus board members on their work as physicians rather than on their own political aspirations, the committee noted. For example, the Board of Trustees chairman should be prevented from immediately stepping into the position of president-elect, and an AMA officer or trustee should be prohibited from becoming executive vice president within three years of leaving office.

Board members, the speaker and vice speaker should also cut the number of days they work on AMA matters by 40 percent over the next four years, the committee said. This would increase the chances they will continue their work as physicians and enable them to bring that valuable perspective to the board's deliberations.

"Board members should be drawn from the physicians who are out there in the trenches," said ISMS President Richard Geline, MD. "If they're less busy, they can continue practicing while serving on the board. Having board members remain in active practice should help dispel the perception that the AMA is a bunch of guys out of touch with the real world."

The AMA needs to clarify the governing and leadership roles of various governing bodies, such as the Board of Trustees, and positions, such as the chairman, president and executive vice president, the committee said. Existing bylaws either fail to provide a complete job description or confuse the issue by assigning similar or identical responsibilities to more than one position or governing body.

For example, the House of Delegates is the AMA's policy-setting body, but the Board of Trustees can interpret and set policy in "urgent situations." A better definition of the board's responsibility can prevent confusion. Among the committee's recommendations is developing an agreed-upon set of fiduciary duties and evaluating the role of AMA standing committees to provide appropriate oversight of board activities.

Other housecleaning recommendations include:

- Create a strategic plan for the AMA's future.
- Review policies related to board members' compensation.
- Plan and establish a risk management program to prevent crises where possible and to respond effectively when needed.

"The Ad Hoc Committee has produced a serious and comprehensive report after many months of hard work," said Randolph Smoak Jr., MD, chairman of the AMA Board of Trustees. "We share their dedication to doing whatever it takes to strengthen the AMA, and we welcome the committee's important contribution to helping us achieve our goals."

The matter will be deliberated at the Interim Meeting, to be held Dec. 6-9. ISMS physicians can contact their AMA delegates to add their own voice to the debate. Call ISMS at (800) 782-4767 for telephone numbers. ■

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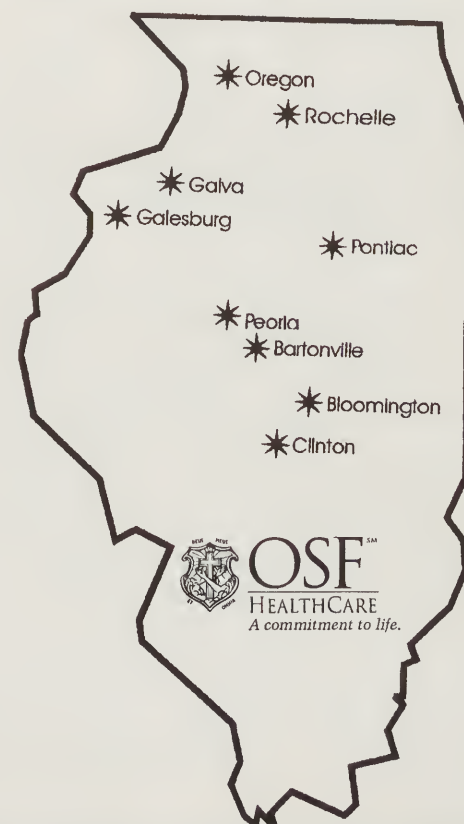
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e-mail: marie.noeth@osfhealthcare.org



State Rep. Richard Winkel Jr. (R-Champaign) and former ISMS President Jane Jackman, MD, discuss women's health issues during a recent legislator breakfast held at the University of Illinois at Champaign by the Governor's Commission on the Status of Women in Illinois. Dr. Jackman is a member of the commission.



William Wiegand

Association exec predicts health issues to top national agenda

Patient protection legislation, Medicare reform and the future of employer-based health care coverage will likely dominate congressional debate in 1999, according to a representative of the country's largest managed care trade association.

Karen Ignagni, president of the American Association of Health Plans, discussed the nation's health care agenda at the annual fall meeting of the Illinois Association of Health Maintenance Organizations Nov. 4 in Rosemont.

Democrats and Republicans will vie to be the first to introduce a patient-protection bill, she said. In addition, Medicare reform will play a prominent role in such legislation. "We're going to enter a major discussion about fixing Medicare through the prism of a year that's going to deal with patient protection," Ignagni said. "I think that environment helps us make the case that various proposals have cost and access consequences, and individuals who are being told to vote on proposals are not getting the full story."

A number of politicians also believe it's time to change the paradigm of employer-based coverage. "I think this will be one of the most potent issues in the presidential election in the year 2000. The situation we have now, with employers providing benefits to employees, is a relic of the postwar effort."

"There is a group of politicians who are going to aggressively promote the idea that it's time to change tax deductibility laws and the way individuals have their health care chosen for them and go to a consumer choice system," she added. ■

Web site

(Continued from page 1)

resources such as "Your Health Matters," an advice newsletter produced by the Society.

Available to ISMS members is a password-protected members-only page on the site that offers the following benefits:

- Access to legislative reports from Springfield and Washington, D.C., with details on how to contact legislators.
- Links to ISMS member resources, including consultant and lawyer referral programs, the physician assistance program, the speaker's bureau and sponsored insurance programs.
- A calendar of all ISMS council, committee and board meetings as well as all-member conferences and events.
- A CME planner's directory.

The password will be included in a promotional mailing about the Web site and can also be requested by calling or e-mailing the Society through info@isms.org.

Meanwhile, *ISMS online* will continue to evolve in order to extend more benefits to members. Future plans include offering chat rooms so physicians can exchange views with their peers, and electronic mail distribution lists that will allow members to receive information on topics customized to their interests. ■

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The managed
care tug-of-war

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Illinois Medicine

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Physician
relax thyself

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Insurer to rethink financial incentives

ISMS ADVOCACY: Under pressure, Blues opts to reexamine controversial policy. BY JANE ZENTMYER

Concerns raised by ISMS, the Illinois Podiatric Medical Association and other medical groups persuaded Blue Cross and Blue Shield of Illinois to reconsider a controversial plan that would have given financial incentives to physicians who steered patients away from hospitals and surgicenters.

The incentives applied to specific foot and ankle surgical procedures, such as a complicated removal of a foreign body from the foot (coded 28193) or repair or suture of tendon, foot or extensor (coded 28208). The Blues proposal would have added \$200 to the physician reimbursements for 55 surgical procedures if they

were performed in an office setting and subtracted \$200 from the payment if the procedures were performed in a hospital or surgicenter. It would have affected podiatrists, orthopods and other physicians who perform the selected foot and ankle procedures.

"Physicians should make patient care decisions based solely on what is best for the patient and his or her specific circumstances — not based on where the insurance company thinks it can get a cheaper deal," ISMS President Richard Geline, MD, said. "This proposal was another attempt by an insurer to interfere in the
(Continued on page 14)



Greg Baker

By sporting a button that reads "It's OK to talk to me about family violence and abuse," Rockford Memorial Hospital emergency room physician Brian Aldred, MD, participates in a program to encourage victims of domestic violence to speak out. The button campaign is part of a project sponsored by the ISMS Alliance.

Malpractice insurance marketplace weakening?

BY PAULA KRAPP

When Frontier HealthCare announced that it would raise its base rates for physician liability insurance in Illinois by nearly 30 percent as of Jan. 1, the move seemed to augur stormy times ahead for the state's intensely competitive malpractice insurance market.

The New York-based carrier's action followed the collapse of Ohio's PIE Mutual Insurance Co. earlier this year and a 5.7 percent increase in premiums in several states by the nation's second-largest professional liability insurance company, Minneapolis-based St. Paul Fire and Marine Insurance Co. Meanwhile, the largest professional liability insurance carrier in the country, Chicago's CNA Financial Corp., is mulling a rate hike. Rival firms could follow suit if CNA raises its premiums for physicians.

Only time will tell if professional liability insurance carriers will be able to control costs regionally, said Frank Dodero, a senior vice president for Aon Risk Services of Illinois, Inc., a Chicago-based insurance brokerage firm specializing in professional liability insurance. "Many are not able to control costs on a national scale because their loss ratios are too high; they go hand-in-hand with the investment market, which has been quite turbulent," said Dodero.

"The rate adjustments from Frontier and St. Paul, combined with other developments,
(Continued on page 10)

Feds finalize 1999 practice expense values

MEDICARE FEES: Office-based services benefit most. BY JANE ZENTMYER

With its eye on a Jan. 1 effective date, the U.S. Health Care Financing Administration plans to push ahead with implementing revamped practice expense values — a move

that's generally expected to shift Medicare money toward primary care physicians and away from specialists.

HCFA kicked off a storm of controversy when it released the new values in November. Eleven physician specialty societies sued the agency, alleging that the revised values would illegally reduce their Medicare payments by \$495 million. (See accompanying story.)

HCFA's revision of the practice expense values stems from a belief that the old methodology it used to develop the values favors procedures and tests performed in hospitals. Under its new approach, the agency attempts to better recognize the actual costs physicians incur for providing a service to patients. This "resource-based" approach recognizes the higher costs of services delivered in an office setting, which are generally provided by primary care physicians, instead of services provided in hospital-like settings, which are generally provided by specialists.
(Continued on page 8)

Reaction Lawsuit filed

The revised practice expense values are unlawful and invalid because the U.S. Health Care Financing Administration ignored Congress' directions for developing the values, alleges a lawsuit filed in November by 11 specialty societies against the government.

The societies contend that HCFA should have used 1997 practice expense values as a base to calculate Medicare payments, instead of the lower 1998 values. They argue that Congress clearly told the agency to use the 1997 values in its 1999 Medicare payment formula.

HCFA's decision to use 1998 values will cost specialists as much as \$495 million, according to the societies. The loss could even climb higher, the groups argue, because many private-sector insurance companies base

their physician rates on those set by the government.

"HCFA has essentially ignored the transition formula that Congress directed the agency to adopt in favor of a formula designed to meet its own policy goals," said Robert Portman, an attorney with Jenner & Block, the Chicago-based law firm representing the medical societies. "The law is very clear in this area: An administrative agency is not free to disregard the plain language of a
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State grapples with standards of care for mentally ill patients

BY PAULA KRAPP

[SPRINGFIELD] Responding to allegations of abuse and neglect of elderly and mentally ill patients receiving care in nursing homes, representatives from the four state agencies that serve those populations acknowledged that improved coordination is needed to upgrade care.

The state must do a better job supervising its treatment programs and do nothing to further break up the system, said Leigh Steiner, associate director of the Office of Mental Health, a division of the Illinois Department of Human Services. Steiner made her recommendations to a bipartisan Illinois House Task Force on Mental Health Care and Patient Abuse legislative hearing held in November.

The hearing was prompted by a three-part Chicago Tribune series, "Warehousing the Mentally Ill in Nursing Homes," that alleged the state dumps mentally ill patients in nursing homes, where they routinely abuse and injure other residents. In the wake of those assertions, the task force invited representatives from state agencies, advocates for the mentally ill and long-term care providers to suggest solutions.

On behalf of the Illinois departments of human services, public aid, public



Refuting allegations that the state has "dumped" mentally ill patients in nursing homes, Leigh Steiner, associate director of the Office of Mental Health, agreed that Illinois needs to better supervise treatment programs.

health and aging, Steiner suggested that a single source, the Office of Mental Health, monitor the services provided by the different agencies that play a role in determining long-term health care treatment plans for the mentally ill. Advocates for the mentally ill also pleaded for

more oversight of state-operated facilities, including nursing homes, that are responsible for providing care to mentally ill patients.

"The state should devise a comprehensive system for investigating individual and systemic problems relating to the abuse and neglect of persons with mental illness in all residential facilities," said Jan Holcomb, executive director of the Mental Health Association in Illinois, a group that champions educational, housing and rehabilitation initiatives for the mentally ill.

Moreover, the state should provide more funding to upgrade facilities and attract more qualified staff to provide care for the mentally ill. "Long-term care facilities and the people who work in them do a good job for the \$72 per day the state provides," said Maria Schmidt, assistant executive director for the Illinois Health Care Association, which represents 450 long-term care facilities throughout Illinois. "But long-term care facilities have a hard time finding the appropriate staff." Added funding is needed to support ongoing training, she said.

Steiner strongly refuted several allegations the newspaper series made about mentally ill patients residing in nursing homes:

- The state does not "dump" mentally ill patients from state hospitals into nursing homes, but instead provides care through the growing number of community-based programs. The 1963 federal Community Mental Health Center Act provided funding for locally based services; in 1998, more than 130,000 individuals received community-based mental health services from nearly 210 non-profit agencies, while 8,977 individuals were admitted to one of 10 state-operated hospitals for treatment. Only 2.7 percent of those patients, or 224 individuals, were discharged from state institutions and placed in nursing homes.

"Admissions to state hospitals have declined from 23,127 in 1993 to 10,675 in 1997, and show that state hospitals have not reduced their census by turning away people, but by building community services to treat people in more appropriate, less custodial set-

tings," said Steiner.

- All mentally ill patients who are placed in nursing homes do not require hospitalization in state institutions. State hospitals provide the most restrictive and expensive form of care for the mentally ill, and involuntary hospitalization is reserved for individuals who harm themselves or others or who are unable to care for themselves. Individuals placed in nursing homes don't meet those criteria, and state law requires that those patients have access to the most cost-effective, least restrictive services for which they qualify.

- The mentally ill patients residing in nursing homes are not routinely abusing elderly residents. Of the 500 most recent cases of abuse and neglect reported to the Department of Public Health, less than 1 percent involved perpetrators who were mentally ill.

Other recommendations Steiner made included the following: require all care givers who treat the mentally ill to become certified in psychiatric rehabilitation; develop standards of care that hold nursing homes and other facilities accountable for the treatment they provide to the mentally ill; screen mentally

TB precautions issued for health care workers

The American College of Occupational and Environmental Medicine recently developed a set of comprehensive guidelines designed to inform health care workers about the dangers of active pulmonary tuberculosis.

An increase in TB cases in recent years and emergence of multidrug-resistant TB strains heightens the risk of health care workers acquiring serious TB infections, which may not respond to usual therapy, said Lawrence Raymond, MD, the lead author of the new guidelines.

Based on input from the Centers for Disease Control and Prevention, the National Institute for Occupational Safety and Health, and the Occupational

Safety and Health Administration, the ACOEM guidelines endorse the use of several strategies to keep TB at bay.

These include updated training of health care workers; optimal design, ventilation and patient traffic flow in clinical spaces; periodic TB testing of health care workers; effective respiratory protection and active infection control procedures. The ACOEM is urging occupational physicians to take a lead role in promoting the guidelines.

The ACOEM is an organization of occupational and environmental physicians dedicated to promoting and protecting the health of workers. For more information, call the ACOEM at (847) 228-6850. ■

Medicaid offers direct deposit to physicians

Physicians waiting for Medicaid reimbursements can now speed up the process by having the state directly deposit their payment into a bank account.

This electronic funds transfer option became available Dec. 1 to the more than 28,000 Illinois physicians currently enrolled in Medicaid. An informational notice about this option was mailed to physicians in late November. "We believe electronic depositing will make it easier for physicians to serve our clients," said George Hovanec, administrator of the division of medical programs, Illinois Department of Public Aid.

The state has made changes in the payment process in order to implement the direct deposit option. A reimbursement check and an explanation of benefits used to arrive in a single envelope. Now the check, or a copy of it, and the itemized list

are mailed in separate envelopes, and office staff must match up the two documents to verify account balances.

Physicians who want to sign up for direct deposit should first check to see whom they've designated as their payee, which is the entity or individual who receives their payment. If a physician has designated a group practice as his or her payee, the group must make the request for direct deposit. If the physician is his or her own payee, the physician must make the request.

Contact the Bureau of Comprehensive Health Services at (217) 782-5565 or the comptroller's office at (217) 524-8403 for additional information. An application for direct deposit is also available on the comptroller's Web site at <http://www.ioc.state.il.us>. (Click on "Sign Up for Electronic Payments.") ■

*Advocates for the
mentally ill want better
oversight of
state-operated facilities,
including nursing
homes.*

ill patients more stringently prior to their admission to nursing homes; and ensure nursing homes develop adequate treatment plans for individuals with a history of violence or aggression so they don't pose a safety risk to others.

She also said the state should provide mentally ill patients with options other than nursing homes. A new licensure category, Residential Rehabilitation Facilities, has been proposed to offer an alternative to nursing homes. This proposal is currently being reviewed by the Department of Public Health's Long Term Care Advisory Board.

After a series of public hearings, the task force will recommend improvements to health care services for the mentally ill. ■

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ISMS gives free clinics a boost

ADDED INCENTIVE: Volunteer health care workers receive immunity. BY JANE ZENTMYER

Free medical clinics on shoestring budgets struggle daily to convince qualified health care professionals to donate their services to needy patients. In the past, recruitment has meant persuading volunteers not only to donate their time, but also to risk liability exposure without malpractice insurance.

Recent changes to state law, however, should help alleviate the fear of hefty civil judgments. In August, immunity from civil damages was given to health care professionals – including advanced practice nurses, physician assistants, social workers, pharmacists and physical therapists – who volunteer in free clinics. Physicians already receive this immunity.

"Immunity from civil liability is going to ease a lot of anxiety for would-be volunteers," said past ISMS President Jane Jackman, MD, who was closely involved in the start-up of HealthFirst Community Clinic in Springfield. "We hope this will increase volunteers' participation so we can deal with the growing problem of the uninsured."

ISMS initiated the proposed change at the request of free clinics and physicians who volunteer for them, and successfully steered it through the legislature. Pamela Fletcher, executive director of the HealthFirst Community Clinic, said the facility plans to send a mailing to all potential volunteers, particularly social workers, informing them of the new immunity. "We really appreciate this," she said, adding that liability fears discourage volunteers.

The immunity to volunteer health care professionals and physicians does not include protection against the rare acts that meet the legal standard known as "willful or wanton misconduct," which means the defendant acted with intentional or reckless disregard for the safety of others. "This standard is very

difficult to prove in court," Dr. Jackman noted.

The new law is expected to help free clinics recruit more health care professionals, but Dr. Jackman said the clinics always need additional physicians as well. The benefits of volunteering extend beyond feeling good about helping patients in need, she said. "Many of the headaches of practicing medicine don't apply to free clinics," noted Dr. Jackman. "You don't have hassles about such issues as utilization review, insurance coverage or patients not being able to afford their treatments."

Dr. Jackman did point out that the immunity protection does not prevent patients from taking legal action. Anybody can sue anybody else for anything, and even if the verdict is in your favor,

Immunity available to physicians at sports events

Thanks to ISMS' lobbying efforts, physicians can now volunteer their services at public events, such as sports games, without undue worry about lawsuit judgments resulting from their well-intentioned treatment.

A recently enacted state law expands physicians' "good Samaritan" protection to include medical care they provide free-of-charge at community events, according to ISMS legal counsel. This law fulfills a 1996 House of Delegates policy that called upon the Society to accomplish this change via the legislative process.

The immunity mirrors the protection currently given to physicians who volunteer at free clinics. The only exception to this protection is for "willful or wanton misconduct."

you're still stuck with the defense costs, she said.

In 1994, ISMIE launched a new coverage option to help physicians defray these defense costs. The policy is available for a small fee to retired physicians and practicing physicians with insur-

ance from carriers other than ISMIE. (Active ISMIE policyholders already have such coverage through their existing policies.)

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PAUL PEDERSEN, MD, looks on as nurse practitioner Sue McGinnes examines 5-year-old Michael Maebane at Community Health Care Clinic, a free clinic in Normal.

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EDITORIAL

Rate hikes rattle the insurance industry

Tremors are rumbling through the professional liability insurance industry that may shake up buyers. As reported in this publication and others, some of the nation's largest medical insurers are raising their rates in response to declining incomes and increasing malpractice claims costs.

For example, St. Paul Fire and Marine Insurance Co., which insures about 50,000 physicians nationwide, has filed for rate increases in several states. Frontier HealthCare is implementing a statewide rate increase in Illinois.

This trend follows on the collapse of the Ohio-based PIE Mutual Insurance Co. earlier this year, leaving about 15,000 physicians without coverage. PIE's downfall, in part, was lowballing product prices to lure customers, a practice that certainly doesn't pay off in the long run if it sacrifices the company's financial well-being.

There are two messages here. One is that, now more than ever, it's crucial to be insured by a financially stable company such as ISMIE. While other insurers have undercut competitor's rates, ISMIE continues its 22-year history of fiscal responsibility. Fair yet realistic pricing guarantees that a company will be there in the future and means that its customers will not be surprised with exorbitant rate hikes.

More than price, however, malpractice

insurance purchasing decisions should take security, service and peace of mind into consideration – values inherent in each ISMIE product. A.M. Best Co., and Standard & Poor's, the nation's leading insurance rating agencies, earlier this year affirmed ISMIE's stability by upgrading its rating.

The other message – legislators pay heed – is that it's time to pass tort reform in Illinois. Juries are increasingly eager to hand over excessively large awards to plaintiffs. In 1997, more than 10 awards to plaintiffs in cases involving ISMIE insureds exceeded \$1 million. By comparison, in 1992 only three verdicts against the defense topped \$1 million.

Lawmakers must wake up and respond to the warnings before history repeats itself. Some legislators have even been around long enough to recall when the average malpractice claim soared in the 1970s, and huge premium hikes followed. The impact of such a financial shakeup in the industry hits consumers as well as physicians if prohibitive insurance rates render some procedures too risky to perform. For patients, it can mean services such as prenatal care and delivery of babies are not available in their area.

Illinois' Governor-elect George Ryan has promised to lead a drive for tort reform to control the runaway legal system. He will need the legislature's help to accomplish this worthy goal. ■

PRESIDENT'S LETTER

Floundering Medicare options raise doubts about system's future

Richard A. Geline, MD



The collision of infinite demand . . . with our nation's finite resources is a step nearer.

Several recent news stories raise concern about the Medicare system.

As part of the 1997 Balanced Budget Act, private insurance companies, hospitals and groups of physicians were invited to offer an array of new types of taxpayer-financed health coverage. With the program called Medicare+Choice, Congress established five new Medicare options:

- HMOs sponsored by medical groups or hospitals.
- Point-of-service HMOs that would let members visit doctors outside the HMO network when preapproved and for an extra charge.
- Provider Sponsored Organization, a provider-owned and -operated managed care plan.
- Government-financed medical savings accounts that include high-deductible policies with tax-advantaged savings for out-of-pocket medical expenses.
- A private fee-for-service arrangement under which providers could bill 15 percent above normal Medicare rates, ostensibly in return for offering patients easier access to services.

Thus far, activity has been only minimal. As of October, only two applications for any of the new plans had been filed. Apparently, because Medicare payments have not kept pace with the cost of care, groups interested in providing any of these programs are having second thoughts.

Medicare MSAs, with all their vast potential, don't seem to be attracting attention. Interest in this type of program by people of all ages, not just seniors, has been disappointing – mainly because the government, which has only grudgingly accepted the concept, has since done its best to mire the idea in obscurity.

On the other hand, hospital and medical groups are resisting the government's invitation to sponsor new HMOs. There seems to be a concern in some quarters that already-existing HMOs envision hospital- and doctor-formed HMOs as competition and are freezing them

out of other business.

Moreover, the government is sending conflicting messages to Medicare beneficiaries. On one hand, it promotes switching to new programs. On the other hand, a government message advises: "If you are happy with the way you receive your Medicare benefits now, you don't have to do anything."

For most elderly Americans who have stayed in traditional Medicare and do not receive supplemental benefits from former employers, the struggle has been to pay rising monthly premiums for Medigap insurance. According to the American Association of Retired Persons, Medigap premiums averaged \$104 a month in the past year.

The cost of Medigap also looms as an issue for some seniors who joined Medicare HMOs, which were supposed to eliminate the need for the costly extra policies. However, established HMOs are dropping out of Medicare, forcing some patients to return to the regular program and seek out Medigap policies once again. Estimates are that 400,000 seniors in 300 counties in 22 states will be affected. In Illinois, one major HMO has eliminated its senior program in the collar counties. Blue Cross/Blue Shield of Illinois has declined to even enter this market.

What does all this mean? The collision of infinite demand fueled by ever-expanding medical capabilities with our nation's finite resources is a step nearer. Intense debate and hard choices lie ahead. As physicians, we will be sternly tested in our traditional role as patient advocates. We must be ready to meet the challenge.

* * * * *

The approaching holiday season is always a welcome time of year. People travel, families reunite, old acquaintances are renewed, gifts are exchanged and warm and generous feelings abound. It's a wonderful moment that always passes much too quickly. From my family to yours, please accept the greetings of the season along with wishes for a healthy and prosperous new year.

GUEST EDITORIAL

Why I don't walk away from my work

BY KERRY K. SWINDLE, M.D.

Is it time to give up my practice and find a 9 to 5 job? That's what I ask myself as I leave the office. Working in an urgent-care clinic, where I could quickly fix up patients and send them on their way, seems more and more appealing. It's only Wednesday, but I'm already burned out this week from listening to assorted demands and complaints from patients and HMOs. Here are just some of the things that have happened:

I received an innocent-looking form from the local HMO. When I read the fine print, I realized I was being reprimanded for keeping a patient in the hospital 12 hours longer than the HMO thought I should. Never mind that she had PID from an IUD. Never mind that she could barely move. According to the HMO's utilization review nurse, once the patient's ultrasound had showed no more abscess, she should have been sent home. What did my clinical judgment matter?

Mrs. Garcia came in again. She hadn't been able to nurse her first child, but was determined to breast-feed her second, born here two weeks ago. The baby had developed significant jaundice, however, and we had sent bilirubin lights to be used in Mrs. Garcia's home. The first set didn't work; the second made loud noises. Mrs. Garcia was stressed, not taking enough liquids, and exhausted. Her milk supply was in danger. I had called to counsel her several times, giving her all the encouragement I could.

Today she had something to cheer about. Her baby had gained 14 ounces in five days, and Mrs. Garcia left beaming.

The HMO sent another form – this one a complaint from a depressed middle-aged patient convinced she has chronic systemic yeast and hypoglycemia. With liquid nitrogen, I'd frozen some actinic keratoses on her legs. She wasn't happy with the way one of the lesions healed and claimed that I should have referred her to a dermatologist. She was also upset that once, while I was walking by on my lunch break, I didn't greet her in the waiting room. I don't remember seeing her, but no matter. Her complaint

means I have another form to fill out, another chart to copy.

Josh came in to have his ear checked. He's almost 4, he told me proudly. Before he left, he made sure I tickled him – a ritual we've established.

I remember the day Josh's mother came waddling down the hall to see me, wanting to know why she'd gained weight and hadn't had a period. She was shocked when I told her she was seven-and-a-half months pregnant. Although an educated woman, she's also somewhat flighty, and needs a reality check from time to time. Josh was born two weeks after that first visit. Luckily, he didn't have a problem as a preemie. A few months later, his parents got married, bought a house, and started enjoying their family.

Anna brought her father in. He has congestive heart failure, hates to take his pills, loves corned beef and beer. Anna's mother recently had a second hip replacement. Anna herself has chronic fatigue syndrome; her meager energy is given to taking care of her ailing parents.

Anna and her family are more than patients – they're friends, and during each visit they bring me up to speed on the rest of the clan. Anna's sister is involved in a sexual-harassment suit at work. One of her nieces is getting married this summer, and another, having finally passed the EMT test, has joined an ambulance company. I was invited to the parents' 60th wedding anniversary celebration. When Anna's dad ultimately succumbs to the beer, corned beef, and noncompliance, I'll attend his funeral.

Many of my elderly patients are joining Medicare HMOs without knowing what they're in for. Most, for instance, don't understand formularies. Why should they? I barely do.

Meanwhile, my paperwork accumulates. Four charts sit on my desk, waiting for me to review calls from pharmacists. Several of the drugs the patients take aren't in the HMO formularies; I have to select substitutes, then explain the change to my patients. Is the patient on an SSRI? Forget it, not covered. What about the



"Lucky you, Mrs. Larison, your HMO says you can stay for another twenty minutes."

new osteoporosis drugs? Sorry, those need to be reviewed before being added to the formulary, and the process will take months. Will my patients understand the changes, take the new pills as prescribed, and get good results? I can only hope.

I write special requests for medications not on the formularies. More forms to fill out and charts to copy.

I decided to be a doctor when I was in junior high. As a medical student, I fell in love with family practice when I treated some of the kinds of families I care for now. I've been in practice for 12 of my 41 years. I never expected to be looking at job alternatives this early in my career. The med-school loans are barely paid off.

Midlife crisis? Maybe. I do know I spend too much time on paperwork, too little tickling my special patients.

Do I really want to give up my practice for a more impersonal job? I don't know. I'm taking a long-awaited family

trip to Maui. Maybe several days in the sun and surf – with as many boogieboard rides as I can fit in – will help clear my head. I hope so.

Postscript: Maui was great. My first day back brought the usual stack of mail, charts, and phone messages. It'll take most of the week to sort through it all.

Josh's aunt came in. She's expecting her first baby. It will be fun to share another birth in that family. New babies are enjoyable not only for the parents and relatives, but also for my staff and me.

I'd love not to have to deal with administrative headaches, but that's not realistic today. So I'll focus as much as I can on the patients and forget the hassle of forms. I won't let the bureaucracy win. I have too many families to take care of. ■

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ISMIE Update

Pulling for patients in the managed care tug-of-war

BY CHRIS PETRAKOS

In this cost containment era, physicians often find themselves the rope in a tug-of-war between managed care constraints at one end and appropriate treatment for a patient at the other.

The danger, of course, is that if the managed care company wins, the patient could wind up a big loser. A real-life example: A patient was released from the hospital despite the physician's request that she remain. The patient's leg eventually had to be amputated — a circumstance that likely would have been avoided had the insurance company listened to the physician.

Certainly it is the physician's duty to pull for the best patient care. But in addition to patient safety, a physician who follows the insurer's direction to offer lower-cost options could later be accused of — and sued for — substandard care.

So increasingly physicians must ask: "How can I balance the requirements of managed care contracts with the obligation to give patients quality health care?" This issue was addressed in a recent ISMIE seminar: "Managed Care Liabilities and Solutions." Its focus was on preserving the physi-

cian/patient relationship while reducing professional liability exposures.

"The relationship between the physician and the patient is primary, not the financial benefits," said John Schneider, MD, one of the seminar's key presenters. Honesty and communication can reinforce this priority, he said. "Think of it as forming a partnership with patients, telling them what you recommend and frankly indicating what services you're capable of providing and what your limitations are in providing those services." The message to patients

in managed care plans should be that they will be treated no differently than patients in fee-for-service plans, Dr. Schneider said.

While managed care companies sometimes place payment over patients, juries see it the other way, according to Oran Whiting, an attorney and partner at the Chicago law firm of Fedota Childers & Rocca PC. For example, in the amputation case mentioned above, the California Court of Appeals found the physician at fault because he failed to appeal the managed care company's refusal to extend the plaintiff's hospital

stay. In other words, arguing in court that "the managed care company said no," is not likely to impress a jury.

Physicians who do go to bat for their patients in conflicts between what a managed care plan will allow and what the physician believes is medically necessary should document their efforts, said Whiting.

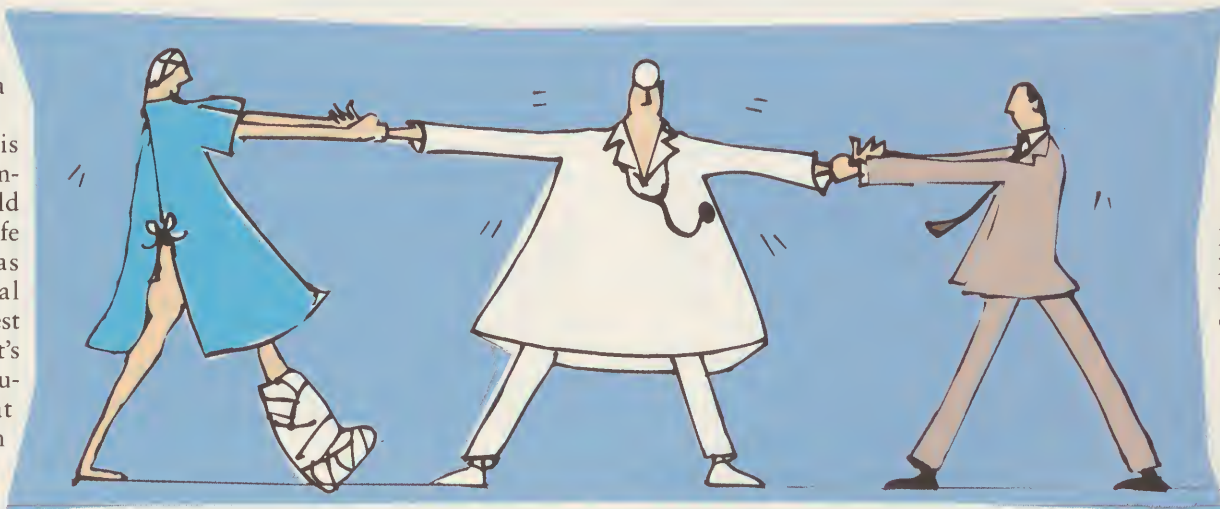
"Every phone call, every letter written on the patient's behalf, every conversation with the patient in which the physician explains the problem and what he or she is doing about it, should be recorded," said Whit-

ing. "It should be obvious in the record that the doctor is screaming for help," he said.

Managed care referral constraints add yet another layer of health and liability risks, Whiting said. Insurance companies often require physicians to refer their patients to physicians within the same plan. While it's a referring physician's duty to be familiar with the physician to whom he or she is referring, many plans are so large that's not always possible. Or, there are times when a referring physician has doubts about the abilities of the physician available through the health care plan.

Here too, honesty is the best policy, Whiting said. Under those circumstances, a physician should inform a patient that the plan limits coverage to in-house referrals, and let the patient know the physician's preference is someone outside the network. Explain that it could cost the patient more to see the physician who is not in the plan, he said.

Lay all cards on the table, Whiting recommends, and provide the patient with a choice. That way, if a lawsuit results, the physician's defense can be that the patient controlled the power of selection. ■



MALPRACTICE ROUNDUP

Jury: Negligence caused memory loss

According to the Oct. 5, 1998, issue of The National Law Journal, an Oswego, N.Y., anesthesiologist was ordered to pay \$1.5 million to a woman claiming that negligence on his part — as well as on the part of a hospital, her surgeon and a radiologist — led to short-term memory loss following a 1994 liver operation.

All but the anesthesiologist had settled before trial. The jury in *Bovay vs. Podolsky* found that the anesthesiologist had failed to adequately replace blood and other fluids during the operation.

Failure-to-inform costs \$3.5 million

In *Laverty v. Monteiro*, a plastic surgeon must pay \$3.5 million to a Pennsylvania woman who claimed she had not been properly informed of the risks of

surgery to remove a recurrent cyst on her tailbone.

According to the Oct. 5, 1998, issue of The National Law Journal, a Philadelphia jury agreed with the plaintiff when she said she was not told before her operation "that the surgery would involve sewing shut her buttocks," or that the surgery would permanently push her rectum forward.

Sexual relations with patient may constitute negligence

A ruling by the District of Columbia Court of Appeals found that, under certain circumstances, any health care professional can be found professionally negligent for engaging in sexual relations with his or her patients, according to the October 1998 issue of *Medical Malpractice Law & Strategy*.

McCracken vs. Walls-Kaufman involved a plaintiff's claim that she was unable to respond negatively to the sexual encounters with her chiropractor because of the medication she was taking.

The District of Columbia already recognizes a cause of action for medical negligence against mental health professionals who have sexual relations with patients, because of the established trust between a counselor and a patient.

The *McCracken* decision expands the existing law in ruling that the same breach is possible in relationships between patients and any health care professionals. According to case experts, the decision serves as a warning to medical professionals to think twice about entering into sexual relations with patients, even if they believe those relations are consensual.



Physician relax thyself

BY JOY LeVEE

While most physicians are content with their career choice, some find themselves regretting their decision to practice medicine. Personal dissatisfaction, fueled by the field's often chronically high stress levels, can create an occupational pressure cooker that can get to even the most initially eager physician. Arguably as important as medical knowledge, learning how to cope with stress is crucial to the functioning and well-being of physicians today. It can mean the difference between a lengthy career and one cut short by burnout.

The possibility of the latter outcome can be minimized, according to Debra Klamen, MD, associate professor of psychiatry at the University of Illinois

at Chicago and director of undergraduate medical education in psychiatry for the College of Medicine.

"Physicians need to be alert for the appearance of signs and symptoms that signal personal overload," Dr. Klamen explained at a recent workshop sponsored by the ISMS Physician Assistance Committee in partnership with the ISMS Alliance. Too often, the typical "type A" person who is attracted to medicine – ironically capable of overcoming the obstacles necessary to become a doctor – finds it difficult to recognize

his or her own stress. Physicians are especially good at denying stress, having learned during their residencies to be stoic and uncomplaining, said Dr. Klamen, who for more than 10 years has directed stress-management workshops for physicians.

The increased emphasis on productivity in an atmosphere of decreasing autonomy and personal control causes serious stress overload for many physicians, she said. To the standard stress physicians experience performing their duties on a daily basis, today's health care environment adds malpractice-litigation fears, business and financial concerns, the intrusion of managed care and heavy ongoing educational demands.

And no physician, Dr. Klamen explained, is unfamiliar with concerns about money and sleep. These notorious contributors to burnout have special meanings for physicians; many medical students graduate with more than \$100,000 of debt, and attending physicians across all specialties average only five hours of sleep per night, she said.

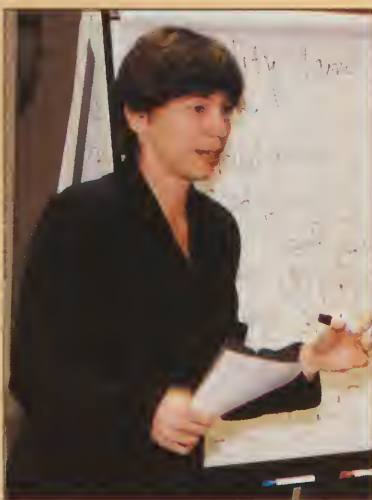
"No wonder so many physicians quit in mid-career," Dr. Klamen said. "If they would take six months off to build self-care and relaxation skills, and learn to cope more effectively with stress, it would give them a better chance to remain productive without burnout. The idea is to do something about your stress before something catastrophic occurs, and you crash."

Married life, as an example, is an area where the adverse effects of abundant work stress often surface. Physician's spouses often find their identities submerged into supporting roles, their needs unfulfilled when their physician wife or husband is pre-

(Continued on page 9)

Photos by Ron Ackerman

Stressing down



Stress can lead to burnout, says Debra Klamen, MD.

Improving interpersonal skills and building sources of social support top the list of ways to avoid and fight stress, according to Dr. Klamen. "People can survive the most amazing stress levels through connection with and support from others," she said. "The 'boot camp' mentality – that sense that we're all in this together – is what helps interns get through that difficult first year." Many people perform best under pressure, and consider stress to be stimulating and necessary. But when pressure produces discomfort, it's time to seek remedies.

Recognizing stress. Signs of stress are many and varied, from physical symptoms such as nausea, vomiting and headaches to problems involving apathy, withdrawal, and drug and alcohol dependency. Anxiety, depression, irritability and anger are other common symptoms; recognizing and dealing with them can help thwart the emotional exhaustion, disconnection, and reduced sense of personal achievement that comes with burnout.

Dealing with stress. Regular exercise, meals and sleep are important stress-busters, as are enjoying hobbies, friends and vacations. Physicians must accept circumstances over which they have no control.

Daily meditation, relaxed breathing, progressive muscle relaxation, autogenic exercises and guided imagery also help defuse stress.

Seeking help. Obtaining outside help is not a sign of weakness. And when physicians think they might be approaching a breaking point, they should follow the advice they would give patients – get the needed help from a qualified professional.



Kathy and Don Pearson, MD, absorb tips to de-stress at a recent stress management workshop for physicians and their spouses held in Springfield.

Reaction

(Continued from page 1)

federal statute."

The lawsuit asks the court to stop the unlawful formula before it goes into effect in January. "If the unlawful regulation is permitted to take effect, hundreds of millions of dollars of Medicare reimbursement will be misdirected, leading to underpayments for thousands of services for which the [practice expense values] were reduced and overpayments for thousands of claims for which they were increased," the lawsuit states.

If the court finds the formula unlawful after payments have been made, specialists may have a difficult time recovering the money that HCFA would owe them. HCFA, the societies note, has a "history of administrative delay" in responding to court-ordered recalculations.

The 11 societies that sued HCFA are as follows: American Academy of Ophthalmology, American Academy of Orthopaedic Surgeons, American Association of Neurological Surgeons, American College of Cardiology, American College of Gastroenterology, American Gastroenterological Association, American Society for Gastrointestinal Endoscopy, American Society of Cataract and Refractive Surgery, Congress of Neurological Surgeons, Outpatient Ophthalmic Surgery Society and Society for Excellence in Eyecare.

Expense values

(Continued from page 1)

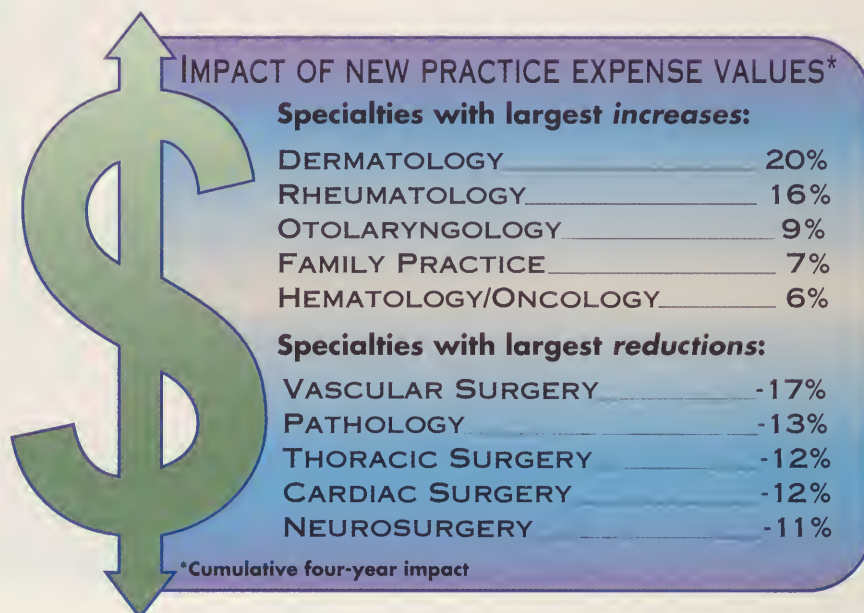
Assuming implementation moves forward, HCFA will phase in the new values over a four-year period, beginning in 1999. The graduated implementation is planned in response to Congress' legislative mandate last year to soften the financial impact on physicians. Practice expense values are the portion of the physicians' compensation that covers costs such as overhead and personnel.

The cumulative four-year impact gives the largest reduction – 17 percent – to vascular surgeons and the largest increase – 20 percent – to dermatologists. Illinois overall is expected to lose Medicare funding under the new practice expense values because of the large number of specialists who practice in the state, according to an ISMS analysis.

All physicians, regardless of specialty, should get annual payment increases to cover the cost of practicing that goes up each year, said Richard Snodgrass, MD, chairman of ISMS' Third Party Payment Processes Committee. "It is important to make sure no specialty is penalized unfairly as a result of Medicare cuts," he said.

The exact impact of the new values on individual physicians depends on their practice's patient mix, explained Dr. Snodgrass. "The government's changes will have more impact on physicians who treat a lot of Medicare patients," Dr. Snodgrass said.

The newest values actually represent



HCFA's second attempt at revision. Its initial revision received strong criticism from organized medicine, which argued HCFA used flawed data to determine physicians' actual practice expenses. Subsequently, Congress included a one-year implementation delay in the Balanced Budget Act of 1997 and made a one-time down payment of \$390 million toward office-based services in anticipation of the impact of the new practice expense values.

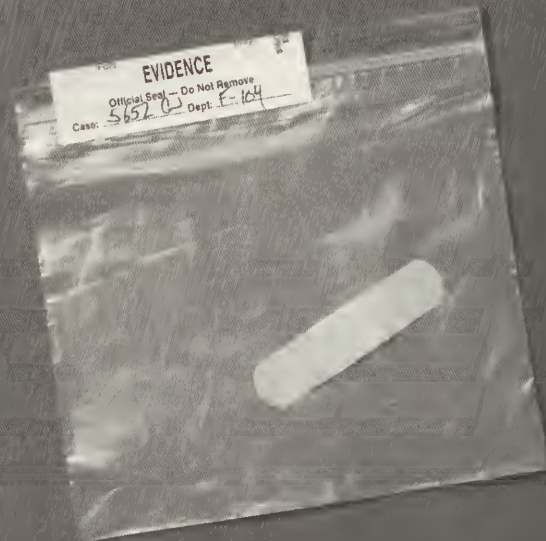
The delay gave HCFA time to redo the resource-based values using better data. Among other things, the 1997 law required new values to be derived from generally accepted accounting principles recognizing all staff, equipment, supplies

and expenses – not just those tied to specific procedures. When developing the new values, HCFA was also required to consult with organizations representing physicians.

Practice expense values account for about 41 percent of the total Medicare payment; physician work and malpractice insurance values account for the rest. To calculate the Medicare payment, HCFA takes the practice, work and malpractice values, adjusts them to reflect geographic cost differences, and then adds them together to reach a total value. That total is multiplied by a "conversion factor" to transform the value into a dollar amount that HCFA will pay for a service. ■

Exhibit A:

Adhesive bandage, which plaintiff alleges defendant pulled rapidly from skin, violently tearing three hairs from plaintiff's arm, which resulted in severe shock, trauma, disfigurement, chronic debilitating pain and permanent psychological damage.



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The St Paul

Medical Services

IDPR DISCIPLINES

This information, published as space permits, is reprinted from the Illinois Department of Professional Regulation's monthly disciplinary report. IDPR is solely responsible for its content.

September 1998

Salahuddin Ahmad, Maryville – physician and surgeon license revoked for violating the terms and conditions of a previously ordered probation.

Earl Caldwell, Highland Park – physician and surgeon license indefinitely suspended for violating the terms and conditions of his probation and for prescribing controlled substances on a non-renewed controlled substance license.

John B. Coe, Benton – physician and surgeon license suspended for one month and controlled substance license suspended for 6 months due to inadequate supervision of nurses and inadequate preparation of inventory of controlled substances.

Leonard Elkun, Chicago – physician and surgeon license reprimanded and ordered to take 40 hours of remedial education in the field of pharmacology after he prescribed Nardil for a patient immediately after the patient was taking Prozac.

James Gage, Morris – ordered to cease and desist the unlicensed practice of medicine after he advertised himself to the public as a doctor in connection with a variety of human afflictions.

Kehinde Ganiyu, Orland Park – physician and surgeon license indefinitely suspended for failing to pay Illinois income taxes.

Michael Gonzales, Highland Park – physician and surgeon and controlled substance licenses reprimanded and fined \$2,300 for failing to complete the continuing medical education requirement of a previously ordered probation and for practicing medicine on a non-renewed license.

Letricia R. Gunaratnam, Evanston – physician and surgeon license reprimanded and fined \$3,000 for illegally diverting fees.

Reda Kilani, Naperville – physician and surgeon license reprimanded and fined \$1,000 due to inadequate maintenance of medical records.

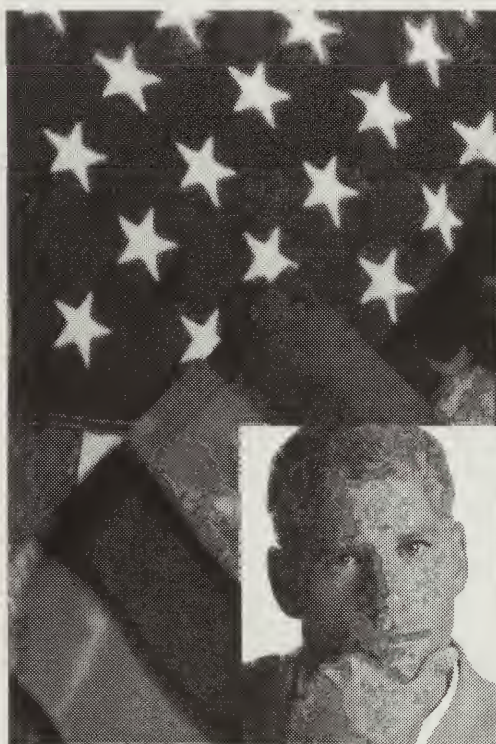
Stephen O. Mallinga, Mbale, Uganda – physician and surgeon license revoked due to gross negligence in the prenatal care of a diabetic patient and in the delivery of the infant.

Franklin C. Miller, Chicago – physician and surgeon license reprimanded and ordered to take 40 hours of remedial education in the field of dispensing controlled substances or successfully complete a tutorial with a preapproved physician for failing to monitor a patient after prescribing a controlled substance.

Lesla R. Seales, Belleville – ordered to cease and desist the unlicensed administration of anesthesia.

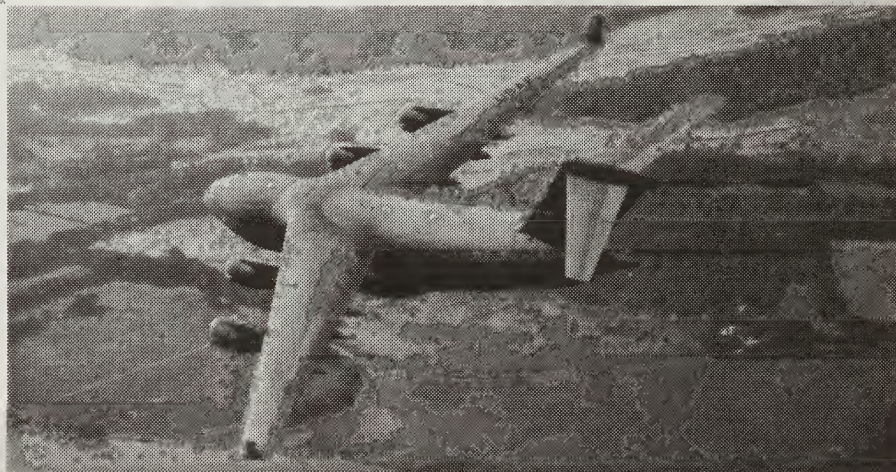
Renato G. Villafuerte, Belleville – physician and surgeon license placed on indefinite probation after being disciplined in the state of Missouri.

Judith Welsh, Chicago – ordered to cease and desist the unlicensed practice of medicine, which includes treating patients, prescribing medication and charging fees after it was discovered she was impersonating a physician at Northwestern Memorial Hospital. ■



PHYSICIANS

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(Continued from page 7)

occupied with patient care. Ultimately, the competing demands from patients and family can lead to anger, separation and divorce. Recognizing and managing stress before these extremes are reached will strengthen and support a marriage and family life.

Overcoming stress can also go a long way toward improving patient relationships. "Although we as physicians often encourage our patients to learn stress management, it is just as important that we learn it ourselves, since a burned-out physician is no good to any patient," Dr. Klamen said, adding that studies show that patients who have a positive relationship with their doctors are much less likely to sue.

"Even adopting one new technique will decrease a physician's stress, and is a crucial element in maintaining a physician's own health in today's abundantly stressful environment." ■

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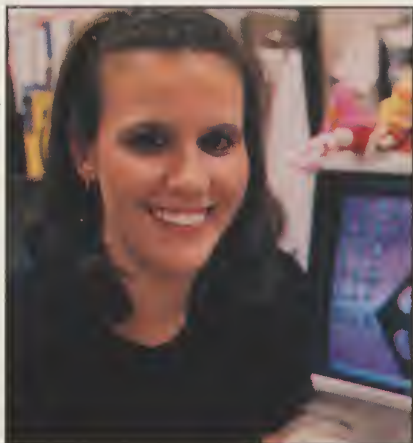
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MICHELLE GUERINE, ISMS management services assistant, was recently honored with the Society's quarterly employee recognition award for her dedication and professionalism. Guerine is responsible for dozens of "behind the scenes" tasks that keep the office environment running smoothly. She is also a key contributor to the "Quarterly Check-Up" employee newsletter.

Insurance

(Continued from page 1)

demonstrate that the malpractice insurance market is hardening a little bit in Illinois as well as nationally," said Harold Jensen, MD, chairman of the ISMIE Board of Governors.

How well liability insurance carriers manage their rising expenses and maintain stable rates will help determine which companies survive if the market tightens up, he said. Professional liability providers that offered profoundly discounted rates may not be able to weather periods of fiscal turmoil without

significantly raising premiums. "We expect to see other companies that came into Illinois with lowball introductory premiums try to make adjustments to their rates to compensate for their overhead," said Dr. Jensen.

"Commercial insurance companies take the interest they make on reserves and bank it as profit because they have to satisfy their shareholders," he said. "ISMIE is stable because it takes the interest it earns and uses it to help subsidize its policyholders. That's a major feature differentiating ISMIE from its competitors."

Illinois' professional liability insurance market sports about 25 to 30 carriers that aggressively vie for market share. That rivalry has kept rates competitive, and new players entering the state have kept premiums down. Although there are individual examples of liability insurance carriers raising rates, experts say Illinois, so far, is not experiencing a broad wash of increases.

"I see only isolated cases," said Doder. "And these companies are still offering sliding-scale discounts on specific risk, so the market is still healthy."

Rate filings have been stable to date, according to the Illinois Department of Insurance. Moreover, not all rate hikes are across the board. St. Paul's premium hike, for instance, affected physicians in 12 states, but not in Illinois.

"Some carriers have been seeking increases on their filed rates, but this has not been turning into increased premiums for Illinois physicians," said Sheila Kelly, executive vice president and managing director of Near North Insurance Brokerage in Chicago. Still, it is one indicator that the market may be hardening, she said.

*A single trigger
could reverse
the current
prosperous course.*

"There are currently no storm signals in Illinois," said David Bickerstaff, a consulting actuary with Bickerstaff & Whatley, a California-based insurance actuarial firm. "The fundamentals that underlie the rate levels, namely claim frequency and average cost per claim, have remained relatively flat or only nominally on the upswing. However, all it takes is one trigger — such as fluctuations in the economy, stock market, claims costs or loss ratios — to reverse the current prosperous course."

One such Illinois trigger that might impact the professional liability insurance industry could come from possible shakeups to tort reform, even in other states. For instance, California's 1975 Medical Injury Compensation Act, which established a \$250,000 cap on noneconomic damages such as pain and suffering, could be reversed by that state's legislature when it convenes early next year.

"If that act is overturned or amended, the aftershocks could extend from California through the rest of the country, hardening up the reinsurance market and leading to rate increases," said Dr. Jensen.

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Illinois' tobacco take: \$9.1 billion

Illinois will receive a \$9.1 billion windfall spread over 25 years for agreeing to a multistate settlement of lawsuits filed against the tobacco industry, Attorney General Jim Ryan announced in late November.

"This is a shining moment for the taxpayers and children of Illinois," Ryan said. "This settlement allows us to recover the billions of dollars taxpayers paid to treat tobacco-related illnesses and gives us the opportunity to channel billions more toward programs to benefit children and public health." ISMS supported Ryan's efforts to sue the tobacco companies.

At least 46 states and the tobacco industry accepted the \$206 billion deal, which must still be approved by the court in Illinois and every other state before it becomes effective. The settlement is the largest in the nation's history. Illinois could see its first payment of \$112 million as early as January, Ryan said.

State officials have not decided how to spend the settlement, but Ryan urged Gov.-elect George Ryan, Gov. Jim Edgar and top legislative leaders to allocate a significant portion of the money to programs for children and public health.

Ryan said he agreed to the settlement because it met or exceeded his litigation goals. "Although we are confident about the strength of our case, this agreement amounts to a guaranteed victory and eliminates any risk that the state would lose at trial," Ryan said.

Following are some of the agreement's other highlights:

- Tobacco companies must funnel \$1.45 billion into a nationwide anti-smoking campaign.
- Industry trade groups that allegedly concealed damaging research will be disbanded.
- Selling apparel, backpacks and other merchandise bearing tobacco logos will be prohibited.
- Tobacco companies cannot target children or teens in their advertising or marketing and must pay \$250 million for a foundation dedicated to reducing teen smoking.
- Cartoon characters such as Joe Camel can no longer be used in tobacco advertising, promotions, packaging and labeling.
- Attorneys' fees above and beyond the costs of the total settlement must be paid by the tobacco companies.
- Tobacco companies do not receive immunity from criminal prosecution.
- Billboards cannot be used for new tobacco advertising, and the state would be able to post anti-smoking messages on billboards that currently have long-term contracts to advertise tobacco products.
- The settlement will be enforced with court orders and with independent legal actions for any future misconduct by the companies. The tobacco industry must also pay \$50 million to an enforcement fund that Illinois and other states can use to pursue violations of the settlement. ■

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Illinois Medicine is published every other Tuesday except the first Tuesday of January and July; ad deadlines are four weeks prior to the issue requested. Although ISMS believes the classified advertisements contained in these columns to be from reputable sources, the Society does not investigate the offers made and assumes no liability concerning them. The Society reserves the right to decline, withdraw or modify ads at its discretion. Ads will be edited to conform to Illinois Medicine style.

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SOME
THINGS
change.

SOME
THINGS
don't.

Blues

(Continued from page 1)

patient-doctor relationship.

"This is the equivalent of telling a physician to ignore his or her medical judgment," said Dr. Geline, who added that it's inappropriate to encourage physicians to perform procedures in an office and then punish them financially when they refuse. "It is not the way to maintain quality or to make health care cost effective."

The Blues seemed to single out podiatrists in the wording of the letter

announcing the financial incentive arrangement in October, said Mary Feeley, executive director of the Illinois Podiatric Medical Association. But, she noted, other foot and ankle providers, like orthopedists, might perform these procedures and would be affected by the Blues policy change.

Several of the procedures that the Blues pinpointed for financial incentives cannot be safely performed in an office setting, Dr. Geline said. Without input from providers, the plan could have seriously compromised patient care.

After an outpouring of complaints,

the Blues agreed in November to delay implementing the questionable proposal until it receives additional input from physicians and other providers. "I'm sorry that the communications were not more focused, were not more complete and that we missed the opportunity to consult beforehand with the [impacted] specialties," said Allan Korn, MD, the Blues' vice president and chief medical officer.

The Blues plans to meet with providers in December to develop an acceptable policy, Dr. Korn said. The Blues' original goal was to recognize the

extra costs physicians might incur when they perform these procedures in their offices. "With additional input, this still might make good sense," he said.

Dr. Geline said ISMS hopes the Blues will respond to the concerns of physicians, and encouraged the insurer to share any evidence it has that physicians should reevaluate their current thinking on these procedures. "Physicians are more than willing to work with insurance companies to develop sound, scientifically based policies that help doctors and patients make the best choices," he said. ■



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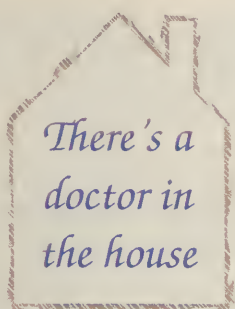
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01/07/99



PAGE 7

Illinois Medicine

ILLINOIS STATE MEDICAL SOCIETY • DECEMBER 25 1998



"Physicians will be very involved in the day-to-day development of policies and principles," said Enrique Beckmann, MD, new chairman of the Reese/Grant board of directors.

Sipping from the Holy Grail

Reese and Grant hospitals enter the brave new world of physician control.

BY JEFF BLACK

King Arthur sought it, but failed in his efforts. Now, topping the legendary king, a group of Chicago physicians believes it is within their grasp: the Holy Grail, at least their version of it.

On Nov. 12, costing \$62.5 million, ownership of financially strapped Grant Hospital and Michael Reese Hospital and Medical Center changed hands. The sale guarantees these physicians part-ownership and, most important, an active, powerful voice in how they deliver health care. To many, this is akin to sipping from the fabled cup.

But is the grail half-empty or half-full? Only time will tell. It's a unique scenario being played out on a very public stage, with physicians throughout Illinois and nationally following the progress of what some see as the best model for the future of American health care.

"We're blazing new territory," agreed Thomas Carlson, MD, an internist and president of the Reese medical staff. "We have a new CEO, Ken Bauer, who did wonderful things at Northwestern [Healthcare Net-

work], and a new president, Steve Weinstein, a savvy turnaround expert from [Doctors Hospital of] Hyde Park."

According to Dr. Carlson, physicians soon will be offered a 20-percent interest in the hospitals. Signaling confidence the institutions will quickly show profits, majority owner Doctors Community Healthcare Corp. of Scottsdale, Ariz., will sell the interest - worth \$12 million - to the physicians for only \$2 million. Dr. Carlson expects at least 200 physicians to participate.

In the future, hospital employees and community groups will each be offered the

(Continued on page 2)

INSIDE

In the 12 months
of this year
ISMS gave to me. . .

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DEPARTMENTS

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AMA pledges change

ISMS seeks incentives for unified states

BY JANE ZENTMYER

ISMS delegates have delivered a strong message to the American Medical Association: develop incentives to reward unified states for their membership in the AMA.

"It appears the AMA board has taken the first step to try to address the problems that unification poses for state societies," said Arthur Traugott, MD, ISMS Board of Trustees chairman and an AMA delegate. Delegations from the four unified states met with AMA trustees for over an hour at the December AMA Interim Meeting to explain their concerns on this matter, he said.

The AMA then pledged to review membership benefits as they relate to unified medical societies as part of its current investigation of innovative membership programs, according to a memo released Dec. 8 by AMA Board Chairman Randolph Smoak, MD. A pilot program may start as early as this

INTERIM MEETING REPORT

spring, and its results will be reported to the House at the AMA 1999 Annual Meeting.

"The Board of Trustees is actively reviewing membership benefits as they specifically relate to unified medical societies, with the goal of developing an additional pilot program designed to recognize the

(Continued on page 9)



Andrew Corrigan Halpern

ISMS Chairman Arthur Traugott, MD, (left to right) and Chicago Medical Society President Janis Orlowski, MD, met Dec. 16 in Chicago with AMA Chairman Randolph Smoak, MD, to hammer out ways the AMA can add value to unified membership.

AMA House approves overhaul plan

In an effort to shore up the American Medical Association's sagging image, the AMA House of Delegates, at its Interim Meeting this month, adopted a plan to rehab the House of Medicine.

Delegates approved with minor changes a report by the Ad Hoc Committee on Structure, Governance and Operations that details more than 36 steps needed to renovate the organization's inner workings. The 10-member committee was created after the much-criticized Sunbeam endorsement raised serious questions about the AMA's direction and performance.

"The House fully supported the steps proposed in the report as a way for the organization to regain its credibility both with its own membership and with the

(Continued on page 9)

State revises hospital order-signing rules

BY PAULA KRAFF

A joint lobbying effort by ISMS and the Illinois Hospital and HealthSystems Association has tentatively resulted in the revision of burdensome hospital licensing rules pertaining to signing verbal and telephone orders.

The revised Illinois Administrative Code allows physicians to sign verbal orders before they leave the area, eliminating requirements that they be signed immediately and be used only in emergencies. Under the pending revisions, the timing to sign telephone orders will be set by individual hospital policy approved by medical staff. This replaces a requirement that they be signed within 24 hours.

The amendments, approved Nov. 18 by the Illinois Hospital Licensing Board, are subject to final approval after public comment.

The revisions put the rules more in step with current medical practices, which rely heavily on telephones and faxes, said Alex Spadoni, MD, chairman of the licensing board and

a physician with a private practice in Joliet. The board believed the 24-hour requirement was too restrictive, particularly because some specialists serve on five or six hospital staffs and make rounds at each site only once or twice a week, Dr. Spadoni said.

The drive for change caught

(Continued on page 10)

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MEDICINE

Holy Grail

(Continued from page 1)

chance to buy up to a 10-percent interest in the hospitals. No time frame for these offerings is set.

Pathologist Enrique Beckmann, MD, newly elected chairman of the hospitals' board of directors, indicated physicians have 10 of the board's 12 seats. On some issues – including capital expenditures over \$500,000 and CEO selection – they will share decision-making power 50-50 with DCHC, Dr. Carlson said.

Dr. Beckmann said Reese/Grant physicians will be "very involved in the day-to-day development of policies and principles," requiring "an increased time commitment for dealing with operational and management issues.

"Our main focus is going back to basics," Dr. Beckmann added, "making sure things like admitting, billing and collections, housekeeping, dietetics and nursing work properly." Already, he said, physicians have been assigned to task forces where they'll work with administrators on improving these areas.

ISMS Chairman Arthur Traugott, MD, praised the physicians who orchestrated the Reese/Grant purchase for "taking charge of their own destiny in a changing marketplace. We hope and expect more physicians will be able to assume market leadership. ISMS is working to encourage and support physicians in these types of endeavors; we look forward to working with the Reese physicians."

DCHC acquired its first hospital in



Thomas Carlson, MD, president of the Reese staff, says critics are threatened by physicians having a say in hospital management.

1992 and, besides Reese and Grant, now owns three hospitals in Southern California, while managing another in the Boston area. "The company doesn't have one template we force on all of our hospitals," explained DCHC spokesperson Sharon Kirsch. "However, we are always focused on physicians making decisions and on keeping health care local."

The purchase was not easy. Last-minute snags and bad press left many wondering if it would ever happen. According to one report, DCHC, which acquires hospitals by taking over their debts, is dangerously overleveraged and

in grave financial peril.

Dr. Carlson vigorously denies DCHC is a shaky partner. "All start-up companies are highly leveraged," he maintained, "because they're constantly expanding. DCHC's debt didn't cause us a moment's pause. Their philosophy is correct. They have large investors who believe in it too, including huge East Coast banks."

But no one denies the hospitals are bleeding red ink. Losses per month are estimated at \$1.5 million to \$2 million, though Dr. Carlson called such figures unreliable, "an accountant's game." Still, he might raise eyebrows by predicting a profit in only two or three months. Simply by ridding themselves of former owner Columbia/HCA Healthcare Corp. and keeping money previously sent to them, he explained, the hospitals will save \$1.2 million a month.

Ken Bauer, new Reese/Grant CEO, said "it's ambitious, but not farfetched" the hospitals could turn a profit within a few months. "It depends on how quickly we increase patient volume," his No. 1 priority. "We'll use one-on-one development with primary care physicians and work hard to bring back physicians who were once with the hospitals, but were driven away."

James Unland, president of Health Capital Group, a Chicago consulting firm specializing in provider networks, said admissions are only the tip of the iceberg. "There is a myth among doctors that the Holy Grail is physician-owned hospitals," Unland said. "[Physicians] say, 'By God, let's straighten this place out.' But it's easier said than done. Physicians don't go to medical school to operate a business."

Dr. Beckmann disagrees with the assessment. "This is an opportunity for physicians to earn the respect we deserve, to prove we are capable of excellent man-

agement as well as excellent medicine," he stated.

Observers also point out that the cost of physical improvements alone could be enormous.

Bauer said \$20 million has been earmarked for capital improvements; upgrading equipment will begin "almost immediately." A "cosmetic reorganization" of the Reese campus will begin some time during the first half of 1999, he added.

Real estate may prove the hospitals'

"ISMS is working to encourage and support physicians in these types of endeavors."

Arthur Traugott, MD
ISMS Chairman

greatest asset, Unland said. Published reports indicate Grant may already be up for sale. Unland says he's heard suggestions Reese could be torn down, with a smaller, more modern facility replacing it. There is also talk of making a deal with real estate developers. "We're exploring all options," Dr. Carlson admitted. "However, we do know that 56 acres on Lake Michigan next to the world's largest convention center is very attractive."

As venerable Reese and Grant hospitals – each with proud histories of more than a century – enter the brave new world of physician control, Bauer shrugs off criticism and says he feels no added pressure knowing Illinois physicians and others anxiously watch from the sidelines. "I knew coming in this was a large and difficult task," he said. "I see it as an opportunity to continue a career-long pattern, working closely with physicians to provide the best health care possible."

Dr. Carlson, too, remains unfazed by critics. "This is a very threatening model to other hospitals," he said. "They're not interested in physicians having a say at their hospitals, so they criticize us and gladly predict our demise."

Stating he feels "encouragement, not pressure," Dr. Beckmann said he's received support from physicians around the country. "However, I caution them that we don't know if this model applies anywhere else. We certainly feel it's the best model for Reese and Grant."

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AMA orders makeover for cosmetics company literature

OOPS: Chicago store's claim in error. BY PAULA KRAPP

A Swiss firm's attempt to tout an American Medical Association endorsement of its de-aging skin care line hit a wrinkle when the AMA issued an immediate cease and desist order.

The action came in response to a promotional flyer La Prairie Inc. distributed at Marshall Field's Chicago store on State Street that – unbeknownst to the AMA – carried the Association's

endorsement for the company's pricey array of caviar-based creams and serums.

The matter carried particular sensitivities for the Association, given last year's Sunbeam endorsement deal, which the AMA terminated in a storm of controversy. Upon learning of the La Prairie endorsement, AMA lawyers immediately asked the company to discontinue the promotion. It promptly complied, said AMA spokesman Robert Mills.

La Prairie's investigation of the incident concluded that the endorsement was due to a misunderstanding by a Marshall Field's employee who viewed a La Prairie training video that was produced by the American Medical Review, a television production company. She apparently confused the AMR with the AMA, the company said.

The AMA was alerted to the endorsement by ISMS member Ann Marie Dunlap, MD, who said it was faxed to her anonymously, but she never believed the

AMA promotion was authentic in light of the Sunbeam incident.

La Prairie executives blushed about the blunder and took steps to smooth over the damage. A representative from La Prairie's corporate office in New York apologized to the AMA in writing for "any confusion this situation may have caused," and said the flyers would immediately be pulled from the store counters and destroyed. The promotional pieces were distributed at only one Marshall Field's store, the company noted. Local media were informed by La Prairie that the AMA does not endorse and never has endorsed its products. ■

IMPAC MCCs bat a thousand

Despite a slushy election-day morning, ISMS Alliance member Vicki Potter and seven other Medical Campaign Coordinator volunteers did everything in their power to ensure that State Rep. Gwenn Klingler (R-Springfield) would secure her third term.

"Instead of watching election returns on TV and saying, 'I hope we win,' we were actually out there getting votes for our candidates," said Potter. Testament to the efforts of people like Potter, all 12 Illinois State Medical Society Political Action Committee-supported candidates – aided by 13 ISMS and Alliance MCC volunteers – won their races. "The MCCs were invaluable on election day," said Klingler, who is married to ISMS member Gerald Klingler, MD. "They organized a great get-out-the-vote effort."

"MCC volunteers make a tremendous impact," said Pam Taylor, an Alliance member who helped create the program in 1986. "Good legislation is made in the voting booth on election day," added Taylor, who noted that ISMS-related activities such as the MCC program will pay off during the next General Assembly, when legislators will tackle a multitude of health care issues, including managed care patient rights.

The MCC program was created by IMPAC to build relationships between the medical community and candidates for the state legislature and Congress. MCC workers – most are Alliance members – volunteer for pro-physician candidates in a variety of campaign duties, including fundraising, literature distribution and making telephone calls.

Potter said part of her work involved building support for targeted candidates by reminding citizens to vote and registering new voters. "The registration drive gave a few more people the opportunity to vote, and the reminders sent a few more people to the polls."

Potter added that her efforts for candidates foster ongoing relationships with the representatives. "They often call to discuss upcoming bills, and when I phone them, they recognize my name as well as IMPAC's." For more information about IMPAC, call (312) 782-1963, or visit the ISMS Web site at <http://www.isms.org>. ■



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Admission Criteria

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- Has a fever or other signs of infection
- Has had an emergent IVP documenting high-grade obstruction with poor visualization of the collecting system on delayed films

Optimal Length of Stay

- 23 hours

Day 1

The patient receives IV hydration and analgesia. An IVP (or ultrasound for patients with contrast sensitivity or renal insufficiency) is obtained and urine straining is begun. Other laboratory tests, such as urine cultures, are obtained.

Note: Patients who pass a stone may have the imaging study done as an outpatient if such a study is still desired by the urology consultant.

Discharge Criteria

The patient:

- Has a temperature less than 100.0
- Experiences pain control with PO medications
- Can ambulate to the bathroom

Note: The patient does not have to remain in the hospital to complete the 24 hour urine collection.

References

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EDITORIAL

Auld Lang Syne rings in with new resolve

As the year winds down, New Year's resolutions get stirred up. Following are some resolutions physicians might consider in order to fulfill the tradition of beginning the new year with a list of things to accomplish in the months to come.

Resolution #1:

Prepare to fend off the pesky Y2K computer bug threatening to emerge with the new millennium. Remember, the stroke of midnight on Jan. 1 not only signals the start of 1999, it sets the countdown running – just 365 days until the year 2000.

The first step in combating the bug is establishing a plan of action to ensure that office and medical equipment is Y2K compliant – which means it won't go berserk when the new century rolls in.

The plan should include a methodical system of vendor contact to learn if products are compliant. Noncompliant systems could confuse the years 1900 and 2000, with disastrous results to patients, billing systems, appointments and any equipment with software or a computer chip.

Resolution #2:

Jan. 1 leaves seven months until medical licenses expire on July 31 for Illinois physicians. Physicians who have moved since their current medical license was issued need to submit a change of

address to the Illinois Department of Professional Regulation. Renewal forms will be mailed in spring, thus the need for updated addresses.

Resolution #3:

Keep up with new Continuing Medical Education requirements. Physicians will need 50 hours of CME for the July 1999 license renewal; the Illinois Department of Professional Regulation will use random audits to keep tabs.

Physicians are required to earn a minimum of 40 percent of their hours in formal, or Category 1. A maximum of 60 percent of the total can be informal, or Category 2. Any hours earned after July 1997 will count toward this requirement.

Resolution #4:

Finally, as the old year fades out, it provides a good opportunity to recognize and extend a warm thank-you to the many kindhearted physicians who regularly donate their time at Illinois' free clinics. Their generous gifts have kept the doors of more than 20 such facilities open this year.

Physicians who have not yet volunteered their services at a free clinic might consider adding that goal to their hope-list of accomplishments to reach in 1999. Call ISMS for the number of the clinic nearest you. It will make a happier New Year for those less fortunate.

PRESIDENT'S LETTER

AMA House deals with issues from inside and out

Richard A. Geline, MD



The matter of unified status was brought up forcefully to AMA leadership.

I recently returned from the AMA House of Delegates interim meeting, a productive gathering where 209 resolutions and 97 comprehensive reports – covering a broad range of topics – were considered. Here are a few of the highlights:

The AMA has essentially reached a deadlock in its ongoing battle to convince the Health Care Financing Administration to abandon the counting requirements from the revisions it is making to the Evaluation and Management guidelines for documenting medical records. AMA Executive Vice President, E. Ratcliffe Anderson Jr., MD, summarized very well the AMA's stand in his opening address: "We made our position clear that our AMA absolutely opposes counting in every way, shape or form." HCFA, however, has been equally clear in return. "Congress demands and will have accountability. Some counting is here to stay."

The House of Delegates countered at the interim meeting with a resolution reaffirming its emphatic rejection of a counting system, directing both the "AMA and the CPT Editorial Panel to expand [their] evaluation to other alternatives for medical records' documentation."

For now, the dialogue continues. Physicians must all be aware that HCFA has recognized and announced the option to design and implement a program alone, without physician input. Meanwhile, work goes on in other quarters to address this issue under the heading ICD10-PCS, which is an even more complicated system combining both physician and hospital activity. The final result might make the current controversial guidelines look simple.

When it came to discussion on the overriding need for antitrust reform, the House was informed about corrective legislation (H.R.4277) sponsored by U.S. Rep. Tom Campbell (R-California), which is currently before Congress. This bill would allow physicians to bargain collectively with HMOs and other health insurance issuers in the same manner exercised by labor organizations under the

National Labor Relations Act, even if such physicians are independent contractors rather than employees. The bill is faltering for lack of sponsors; grass-root physician support is essential.

As for the AMA's internal concerns, the last vestiges of the Sunbeam affair have been mercifully laid to rest. Following a charge from the House of Delegates 1997 interim meeting, a special ad hoc committee on structure and governance brought forth a comprehensive report with more than 36 AMA reform recommendations.

The entire House debated the matter for the major portion of an afternoon. The result of that dialogue: AMA bylaws will be amended to include a chairman and a chairman-elect as board officers, each limited to a single, one-year term, with the chairman-elect automatically succeeding to chairman. As amended, the chairman will be precluded from immediately running for the position of president-elect, and no AMA officer or trustee will be eligible to serve as executive vice president within three years of leaving office. In addition, the structure and amount of compensation for the Board of Trustees will be determined by a newly established committee of the House of Delegates, rather than by the Board itself.

Another major issue of the interim meeting was the matter of unified status, which was brought up forcefully by the Illinois Delegation to AMA leadership. In a special memorandum, the Board of Trustees responded by announcing a goal to develop a pilot program specifically designed for unified societies that aims to recognize the special contributions these organizations make to the federation.

Illinois' message from the special ISMS House of Delegates meeting in September demanding AMA accountability seems to have been received. Watch for further developments prior to our House of Delegates annual meeting in April 1999.

Finally, let me extend to our members, their families and all our patients best wishes for the new year.

ISMS: The gift that keeps on giving

BY EDWARD FESCO, MD



Many people in the past few weeks have been thinking about presents – either dreaming of the ones they might receive, or more likely fretting over the ones they need to buy for others. Unlike the last-minute shoppers among us, our state medical society does its gift-giving all year long. I came up with this little song to remind us of everything ISMS accomplished in 1998, many times working hand-in-hand with legislators, the AMA, specialty societies, political activists and others. As you will probably guess, it's sung to the tune of The Twelve Days of Christmas. So join right in with me.

**In the first month of this year,
ISMS gave to me:
Managed care accountability**

**In the second month of this year,
ISMS gave to me:
A chance for earning CME
and managed care accountability**

**In the third month of this year, ISMS
gave to me:
KidCare growth
earning CME
and managed care accountability**

**In the fourth month of this year,
ISMS gave to me:
A Medicaid increase
KidCare growth
earning CME
and managed care accountability**

**In the fifth month of this year, ISMS
gave to me:
PATIENT RIGHTS BILLS
Medicaid increase
KidCare growth
earning CME
and managed care accountability**

**In the sixth month of this year, ISMS
gave to me:
A strong voice in Springfield**

**PATIENT RIGHTS BILLS
Medicaid increase
KidCare growth
earning CME
and managed care accountability**

**In the seventh month of this year,
ISMS gave to me:
A better AMA
strong voice in Springfield
PATIENT RIGHTS BILLS
Medicaid increase
KidCare growth
earning CME
and managed care accountability**

**In the eighth month of this year,
ISMS gave to me:
A presence in D.C.
a better AMA
strong voice in Springfield
PATIENT RIGHTS BILLS
Medicaid increase
KidCare growth
earning CME
and managed care accountability**

**In the ninth month of this year, ISMS
gave to me:
Judicial race endorsements
presence in D.C.
a better AMA**

**strong voice in Springfield
PATIENT RIGHTS BILLS
Medicaid increase
KidCare growth
earning CME
and managed care accountability**

**In the tenth month of this year,
ISMS gave to me:
A great new Web site
judge race endorsements
presence in D.C.
a better AMA
strong voice in Springfield
PATIENT RIGHTS BILLS
Medicaid increase
KidCare growth
earning CME
and managed care accountability**

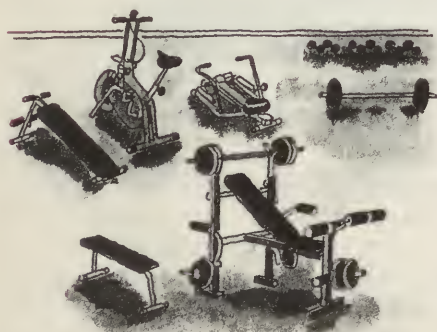
**In the eleventh month of this year,
ISMS gave to me:
A doc-friendly gov'nor
a great new Web site
judge race endorsements
presence in D.C.
a better AMA
strong voice in Springfield
PATIENT RIGHTS BILLS
Medicaid increase
KidCare growth
earning CME
and managed care accountability**

**In the twelfth month of this year,
ISMS gave to me:
New HMO guides
Doc-friendly gov'nor
a great new Web site
judge race endorsements
presence in D.C.
a better AMA
strong voice in Springfield
PATIENT RIGHTS BILLS
Medicaid increase
KidCare growth
earning CME
and managed care accountability**

I would be remiss if I didn't acknowledge there are also "presents" I couldn't fit under this musical tree that were just as important to doctors and patients: the revised "A Personal Decision" advance directives brochure, improvements to the state Ob/Gyn access law and progress toward a name-reporting system for HIV infection are just a few.

I also know that ISMS did not single-handedly reach these goals. The holiday season is not only another opportunity for physicians to count the blessings we receive from ISMS, but also to appreciate the individuals and the organizations that work with us to achieve gains for patients and physicians.

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Coming soon:
The aftermath
of ending a
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ISMIE Update

ISMIE Academy

Series founded to teach the art of good customer service

A patient who has lost his or her patience is showing the symptoms of a dissatisfied customer. And it takes only a little extra disregard to turn a dissatisfied customer into a litigious customer.

Despite managed care, patients still exert a considerable amount of choice in physician selection, and patients who feel comfortable with their physicians are more likely to seek and accept that physician's medical advice.

Unfortunately, many patients today feel that their doctors don't care about them as much as they used to. Whether true or not, perception can quickly become reality, and should a legal situation arise, the physician will be the primary target of blame for a patient's entire medi-

cal experience, including any discourtesy by the office receptionist, the nurse or the referral coordinator. However, an understanding staff adept at dealing with people can help disarm that possibility.

Promoting customer-oriented service is the focus of the newly formed ISMIE Academy, offering seminars designed to provide educational and motivational opportunities for ISMIE-insured physicians and their office staffs.

"Everyone in the physician's office should have a positive attitude toward service," said Jane Jackman, MD, chairman of the ISMIE Policyholder Services Committee. "Otherwise, the efforts of even the best physicians can be undone."

These seminars provide value-added service for insureds, said Dr. Jackman. Most physicians have little time to provide training for their staff or to research commercially available training programs. "The service is unique among insurers," Dr. Jackman noted. "There are many seminars on billing and office management, for instance, but we believe we're the only insurer to specifically gear training to customer service issues."

The first one-day seminar, "Creating an Atmosphere for Service," addresses pivotal customer-relations topics such as patient service skills, telephone etiquette, advanced communication techniques and dealing with difficult people.

The schedule for repeat presentations of the program is as follows: Feb. 16, Peoria; Feb. 18, Collinsville; and March 2, O'Hare Marriott, Chicago. If the pilot program is successful, ISMIE Academy will present seminars on additional topics. For more information, contact the ISMIE Outreach Department at (312) 782-2749.

First lesson: Office protocol 101

BY JOY LE VEE

"Improving customer service is harder for a physician's office than it is for a department store, but it can be done," said motivational speaker Doug Stevenson at a recent customer service seminar sponsored by the ISMIE Academy.

"A physician's office is a unique place, with intense time and people pressures. As professionals, you face the challenge of treating all patients, no matter how difficult they may behave, with kindness, empathy and compassion."

In "Creating an Atmosphere for Service," Stevenson took participants through a day of practical and highly-targeted advice, lively discussions and role-playing activities. According to Stevenson, an atmosphere for service requires a friendly and courteous staff, procedures that are easy to understand, and an inviting and comfortable physical environment. These assets are welcome in any office, but particularly to physicians they are key components of good patient care and patient retention.

"Compassionate and empathetic people are the foundation of any successful patient service campaign. Physicians and office staff must care enough about

the patient to be willing to change their behavior to meet the patient's needs," said Stevenson, a business trainer based in Colorado Springs, Colo., who specializes in the areas of change, leadership, customer service and motivation.

"It takes a friendly attitude and an optimistic belief system. Even when your patient has an inoperable brain tumor, you can still offer compassion, support and hope."

Maintaining a positive attitude in a stressful physician's office isn't easy, he added. "In the real world, how many hours can you smile each day? Develop acting skills, so you can repeat the same words in a kind pleasant voice all day long. Take control of your thoughts and learn to laugh. Remind yourself that whatever is going on, it could be worse. And if things are really tough — let's say you just diagnosed a patient with AIDS — then step outside in the fresh air for a moment."

Among the physicians, office managers and other staff attending the seminar was Paul Goldberg, MD, a radiologist at Edward Hospital in Naperville. Dr. Goldberg said he planned to incorporate some of the seminar suggestions into his practice. "Medicine is different from

getting your car fixed," he said. "It is getting harder all the time to meet our patients' expectations, especially since everybody is so short staffed."

Another participant was JoAnne Lightfoot, a receptionist for a five-doctor family practice in Arlington Heights that includes her husband, John Lightfoot, MD. The office staff now works hard to keep patients satisfied by quickly answering ringing telephones and by getting patients in and out of the office on time, she said.



That often means, for example, preventing physicians' schedules from becoming overbooked so that patients aren't lined up in the waiting rooms. "There's always a struggle trying to determine how many openings you leave for emergencies," Lightfoot said. "We're always trying to fine-tune [the scheduling process]."

On rare occasions, patients might complain to physicians

about how the office personnel treat them, Lightfoot said, and staff is always looking for tips that will help their relations with patients. "We're trying to see if we can eliminate [the complaints] completely," she said. "Although customer service has always been a priority in our office, the seminar gave me some good ideas that should lead to improvements."

Suggestions put forth by Stevenson for improving physician-patient relations include:

- Take a Polaroid picture of all new patients, and put the pictures in their files. This low-cost practice lets you recognize your patients and greet them by name.
- Ask patients how they wish to be addressed and document this in their files.
- Write patient information by hand, and enter it into the computer later. Direct entry disconnects the caregiver from the patient.
- Look for clues to a patient's personality — hobbies, family, etc. — and include this information in the file.
- Communicate policies and procedures clearly and often. For example, patients may erroneously expect office staff to help them fill out insurance forms. Printed instructions and



Julia Anderson-Miller

posted signs are useful.

- Reduce frustration and anxiety in the waiting room by warning patients when the doctor is running late; don't let them feel forgotten.

- To make waits more tolerable, have telephones available for local calls, show health-education videos on the television or provide radio earphones. Current magazines and newspapers are also a must.

- Never argue with a difficult patient. Instead, ask in a pleasant voice, "How can we work this out together?"

"Remember, patients see themselves as customers, and they expect personal attention and understanding," Stevenson said. "You can exceed their expectations by personalizing your relationships. Organizations all around the world do this and medical professionals can do it, too."

There's a doctor in the house

Home health care is making a comeback

BY PAULA KRAPP



SEEING 89-YEAR-OLD MARY SALERNO seated at her dining room table, it's hard to believe she is receiving comprehensive medical care. Yet in the comfort of her Wheaton home, a finger-sized oximeter reads her pulse while a medical technician in the adjacent chair checks her blood pressure and prepares to get a blood sample. Supervising the scene, a physician reviews his notes from the previous visit while asking Salerno about her condition.

This is not unique. It is, in fact, increasingly common as a growing number of physicians are providing high-quality, cost-effective patient care in a home setting. It's definitely the way to go, said a contented Salerno, who is in a wheelchair and dislikes leaving home.

The re-emergence of house calls like these is in part due to soaring patient need and increased interest in geriatric care, said George Taler, MD, president of the American Academy of Home Care Physicians. The Baltimore-based organization of nearly 800 physicians aggressively lobbies for increased reimbursement formulas and other benefits for home care providers.

As the U.S. population ages, there is a rising demand for home-based health care, but not the quaint image of physicians visiting homes with black bags containing basic medical supplies. Today's visits include hi-tech portable equipment capable of advanced procedures such as electrocardiograms, X-rays, ventilator care and dialysis.

"Our mission is to improve patients' quality of life, keeping them in stable condition and out of hospitals or nursing homes," said Tom Cornwell, MD, Salerno's physician and the medical director of HomeCare Physicians in Carol Stream. HomeCare Physicians,

consisting of two physicians and one nurse practitioner, works closely with 15 home health agencies and hospices to provide interdisciplinary primary care services for 350 patients in the DuPage County area.

"Many of these sickest people are confined to their homes due to physical and financial conditions," said Dr. Cornwell. "One goal of providing home health care is to prevent hospitalization. Averting just a single hospital visit covers the cost of a year of monthly HomeCare visits." Dr. Cornwell joined HomeCare Physicians, a division of Centra, Central DuPage Health System's group medical practice, in February 1998. He explained that in its first 18 months, HomeCare Physicians has made more than 3,000 house calls and recently treated its 600th patient.

Demonstrating the effectiveness of these house calls, Dr. Cornwell cites Salerno, who was hospitalized six times in 1997 for complications related to diabetes, congestive heart failure, anemia, hypertension, arthritis and asthma. Since the house calls began last December, Salerno has not returned to the hospital, and is thriving physically and mentally.

Nearly two-thirds of the HomeCare Physicians' patients are approximately 78 years old and female, but there are several younger patients who are homebound due to muscular dystrophy, multiple sclerosis or spinal-cord injuries. In addition, 98 percent of home care patients are on fixed incomes and receive Medicare, while another 2 percent are on Medicaid. According to the

Technology advancements are one reason behind the growth in home-based health care that is giving many patients expert medical treatment in familiar surroundings. Above: With son Robert MacGaffey at her bedside, Marjorie Behr is treated by Tom Cornwell, MD. Left: Dr. Cornwell reviews his patient's records. Below: Medical technician Enrique Via-Reque retrieves Behr's medicines from a kit that bears only slight resemblance to yesterday's little black bag.



Photos by Markus Giolas



(Continued on page 9)

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AMA overhaul

(Continued from page 1)

public," said Arthur Traugott, MD, ISMS Board of Trustees chairman and an AMA delegate. "The report will bring the AMA into an era of consumerism and accountability."

Key points adopted include:

- Prohibiting the AMA Board of Trustees chairman from immediately succeeding to the position of president-elect and preventing any officer or trustee from becoming executive vice president within three years of leaving office.

- Requiring the House to hold the Board of Trustees accountable for proper oversight of the organization, but not through the recording and publication of individual votes – an approach previously suggested by ISMS delegates. Instead, the Board as a whole and each trustee individually will undergo a self-evaluation to assess their performance and to highlight areas for improvement.

- Clarifying the board's responsibility to be one of oversight of the AMA. All operational business matters, such as personnel and facility issues, should be referred to the executive vice president.

- Planning a risk management program to prevent crises where possible and to respond effectively when needed.

- Creating a strategic plan for the AMA's future and ensuring that ongoing initiatives and new undertakings are measured against the plan.

- Establishing a committee of the House of Delegates to determine board members' compensation.

- Hiring independent expertise to determine the value of trustee appearances at speaking engagements, with specific suggestions for improvement to be sent back to the House in 1999. The AMA House rejected a recommendation from the ad hoc committee to reduce the number of trustee workdays by 40 percent so trustees could increase the time they spend practicing medicine.

Unified states

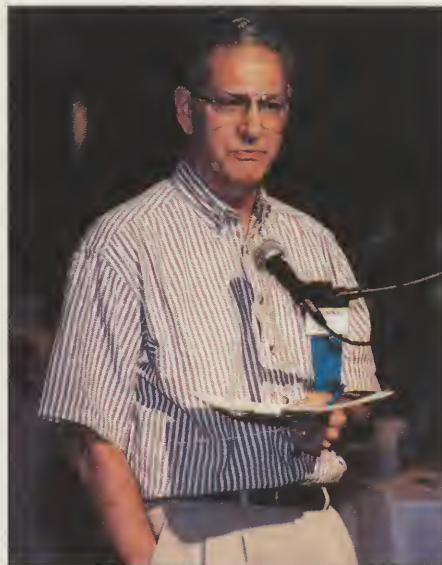
(Continued from page 1)

special contributions these organizations make to the Federation," Dr. Smoak said. "If successful, this program will be a strong selling point for unified membership status."

ISMS met again with the AMA on Dec. 16 to discuss additional details of the program, Dr. Traugott said. Several concepts for a pilot program addressed at the meeting included improved communications and liaison between the AMA and unified states, and clarification of membership issues.

The AMA already has pilot projects under way in several nonunified states and hopes to present the House with results from those projects at the 1999 Annual Meeting, Dr. Smoak said. The projects test several concepts, including the idea that membership may increase if physicians are provided with multiple levels of benefits and dues.

After learning of experimental dues reductions being tested in other nonunified states, the Illinois delegation pushed



Ted Grudzinski/AMA

ISMS delegate Alfred Clementi, MD, speaks from the floor at the AMA Interim Meeting held this month.

for a pilot project in a unified state, said Edward Fesco, MD, chairman of the Illinois AMA delegation. "Illinois should be considered for a dues reduction," he said. "If the AMA is going to have a

pilot program, why not have it with a unified state?"

The current pilot projects are complex and were finalized late in the calendar year, which limited the states in which they could be offered, Dr. Smoak explained in the memo. To ensure accurate results, the projects were implemented in states that allow for controlled monitoring and can provide fair comparisons to see which ideas work.

Until the outcomes have been analyzed, it is not feasible to deploy the pilot programs on a widespread basis, Dr. Smoak said. "The financial impact on the AMA and on state societies is not known, and there is a possibility that some of our experiments will result in a decrease in dues revenue."

The AMA has made membership its top priority, Dr. Smoak said, and the pilot projects are helping the organization identify new, effective formulas for member recruitment and retention. "The objective is to implement programs that will have a positive impact on membership, not only for the AMA but also for all levels of the Federation," said Dr. Smoak. ■

Doctor in the house

(Continued from page 7)

Health Care Financing Administration, which oversees Medicare, there were 1.5 million individual claims nationwide for home health care in 1997.

"Home visits can be very rewarding for the providers and the patients," said Joanne Schwartzberg, MD, director of the department of geriatric health for the American Medical Association. "Physicians get a better view of how their patients function during a home visit. They see much more than they would in an office, and physicians who make house calls inevitably say, 'This is what I went into medicine for.'"

Despite that satisfaction, however, the numbers of home care practitioners are held down by low pay and a lack of role

models, said Peter Boling, MD, past president of AAHCP and associate professor and director of the Home Care Program at the Medical College of Virginia.

"Doctors making home visits still don't earn as much as plumbers who make house calls," said Dr. Boling. According to the Plumbing Council of Chicagoland, licensed plumbers on average earn \$75 per hour; under Medicare's formula for home visits, physician reimbursement rates start at \$46 per visit.

That trend may soon turn, however. Under a new Medicare fee schedule effective Jan. 1, physicians' reimbursement rates for house calls will increase, Dr. Boling said. Visits with moderately ill to seriously ill patients with multiple chronic illnesses will be reimbursed on a sliding scale of roughly \$100 per call. "The new rates might encourage more physicians to provide this important

service," he added.

Another impediment to home health care has been the fact that most physicians lack training in medical management of patients in their homes. "Few medical programs require house calls as a part of residency training," Dr. Taler noted. "But more internal and family medicine programs are beginning to require house call experience, which means more physicians trained in this area."

As Dr. Cornwell and his technician, Enrique Via-Reque, prepare to leave Salerno's house, she thanks them with a few cookies, some fruit and several pieces of candy. Gifts such as these are frequent for physicians after home visits, heartfelt expressions of the patient's appreciation. Happy to avoid the trauma of leaving home, Salerno said, "I thank God for Dr. Cornwell. I get such good care from him." ■

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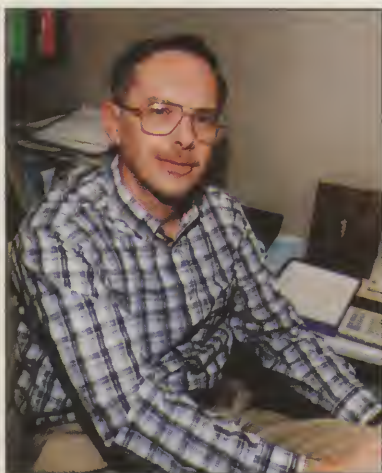
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Amy Rothblatt

RON KOVES, ISMIE senior underwriter, was a recent recipient of the Society's employee recognition award. Koves was honored as an unsung hero who strives to achieve a high standard of personal and professional excellence.

Hospital rules

(Continued from page 1)

fire last summer when the Joint Commission on Accreditation of Healthcare Organizations cited St. John's Hospital in Springfield for noncompliance after discovering that 650 physicians had not followed the signing rules. In response, John Holland, MD, the hospital's retired medical director, who now works for St. John's Hospital Hospice, sought a remedy for what he said were the anachronistic and onerous hospital licensing rules.

"The current guidelines can't be

enforced for a multitude of reasons, including the fact that some physicians do not perform daily rounds," said Dr. Holland. He requested assistance in fighting for change from the Sangamon County Medical Society, which in turn notified ISMS of the matter. The Society, working with IHHA, had already been championing changes to the medical order guidelines that both parties agreed were outdated.

Rectifying the rules for medical orders made sense to hospital administrators because the existing guidelines jeopardized accreditation, said IHHA Assistant Vice President Ann Guild.

Hospitals cited for failing to comply with the rules lost accreditation points. The 24-hour countersigning requirement interfered with hospitals' ability to provide quality patient care, according to Guild. "Hospital personnel spent an inordinate amount of time handling countersigning issues brought up by JCAHO surveyors," she said.

"It would be tragic to have an excellent hospital lose accreditation, or potentially lose its accreditation, because of rules that really don't make sense in the given set of circumstances," noted Lawrence Hirsch, MD, a member of ISMS' Council on Medical Service,

which is monitoring this issue. Dr. Hirsch is also a member of the hospital licensing board.

Many physicians welcomed the action to remove the stringent medical-order requirements they said are often unworkable. "Physicians have undergone ridiculous hassles trying to comply with the countersigning rule," said John Stoll, MD, an internal medicine specialist for Carle Foundation Hospital in Urbana, noting that it robs physicians of time for patients. "We should be able to countersign orders when we sign off on a chart."

Although the concept of signing verbal orders before leaving an area is laudable, it is not practical, said Napoleon Knight, MD, an emergency room physician for Carle Clinic Association in Urbana. "Even if the physician is on site, the patient and his or her chart could be in another part of the facility and not readily available. It can be disruptive to patient care if physicians have to conduct a search for the chart just to sign an order."

The new rules could be enacted in four to six months, according to Illinois Department of Public Health spokesman Tom Schafer. The amendments first will be published in the Illinois Register, followed by a 45-day comment period. The licensing board can accept or reject additional recommendations, and then they will be implemented. ISMS will continue to closely monitor this issue. ■

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SOME THINGS
don't.

HCFA backs off anesthetic plan

A proposal from the U.S. Health Care Financing Administration that sought to change what the government considers "medical direction" in the delivery of anesthetic care fell by the wayside in November when the agency opted to stick with its existing policy.

ISMS, the American Medical Association and other groups vigorously opposed HCFA's altered definition of medical direction, which was released in June 1998, charging that it placed unreasonable administrative burdens on physicians who supervise certified registered nurse anesthetists and other anesthetic care providers.

Medical direction, as defined by HCFA's existing policy, means that physicians must perform the following actions before the government will recognize their supervisory work: conduct a pre-anesthetic exam and evaluation, prescribe the anesthetic plan, participate personally in the plan's most demanding aspects, ensure qualified individuals perform the procedures, monitor the course of anesthetic administration at frequent intervals, remain physically present and available for immediate diagnosis and treatment of emergencies and provide indicated post-anesthetic care.

The agency's action doesn't change physician reimbursements for medical direction provided for anesthetic care. Current law allows physicians to receive 50 percent of the fee that would have been paid if the physician — instead of another provider — had provided the service. ■

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